



Indian Health Service FY 2001 Performance Plan and FY 1999 Performance Report

February 18, 2000

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Part I - AGENCY CONTEXT FOR PERFORMANCE MEASUREMENT

Tomorrow

We have wept the blood of countless ages as each of us raised high the lance of hate.

Now let us dry our tears and learn the dance and chant of the life cycle.

*Tomorrow dances behind the sun in sacred promise of things to come for children not yet born,
for ours is the potential of truly lasting beauty, born of hope and shaped by deed.*

Peter Blue Cloud

Overview of the Context of GPRA in the IHS

The Indian Health Service (IHS) has embraced the Government Performance and Results Act (GPRA) and its requirements as an extension of the public health approach that we have used for almost a half of a century. In this document the final FY 2001 and revised final FY 2000 Performance Plans have been merged with the FY 1999 Performance Report consistent with the required format developed within the Department of Health and Human Services (HHS). This plan is submitted as an incremental step in complying with the Secretary's Initiative to eliminate racial and ethnic health disparities and the President's Initiative to Eliminate Disparities in Health Status Among Americans. Consistent with the proposed *Healthy People 2010* goal of achieving equivalent and improved health status for all Americans over the next decade, this plan outlines a strategic set of performance indicators to address the significant health problems of the American Indian and Alaska Native (AI/AN) population.

Indeed the disparity in health status that the IHS must address is formidable, particularly in terms of death rates. Comparing the 1994-1996 Indian (IHS service area) age-adjusted death rates with the U.S. all races population in 1995 reveals greater death rates in the AI/AN population for:

- | | |
|---|---|
| 1) alcoholism - 627% greater, | 6) pneumonia and influenza - 71% greater, |
| 2) tuberculosis - 533% greater, | 7) homicide - 63 % greater, |
| 3) diabetes mellitus - 249% greater, | 8) gastrointestinal disease- 42% greater, |
| 4) unintentional injuries - 204% greater, | 9) infant mortality - 22% greater, and |
| 5) suicide - 72% greater, | 10) heart disease, 13% greater. |

It was not surprising that a recent Harvard School of Public Health/Centers for Disease Control and Prevention (CDC) study found that the lowest life expectancies in the country (including inner city ghettos) for both men and women exists in Indian communities. These rates are similar to ones seen in sub-Saharan Africa and are the lowest of any nation in this hemisphere except Haiti. It is also not surprising that these Indian people have also been identified as living in the poorest counties in the country. Even more alarming, the most recent data (provided in Section 1.2 of this plan) documents that the mortality disparities for AI/AN people are actually worsening.

Despite these formidable challenges, the IHS in partnership with its stakeholders, view the GPRA as part of the process for assuring the capacity to serve AI/AN people. We are optimistic about the future and encouraged and appreciative of the support of the Department, OMB, and Congress in the development of this and last year's budgets and of the improved level and quality

of consultation that has occurred with tribes. In particular, the regional meetings/ listening sessions convened by the Department's leadership provided a valuable dialogue process that was informative and empowering to the AI/AN people and should contribute to enhanced collaborative activities within and outside the Department.

The performance indicators and requested funding increases supporting this plan are predominately directed at improving access to health services for AI/AN people. However, it is important to acknowledge that due to the nature of many of the diseases and conditions afflicting AI/AN people, they are not likely to respond immediately to increased access to services. Like an ocean liner or large freight train which continues to move forward for a considerable time even after the engines are reversed, so will some chronic and/or life-style related conditions continue to afflict the AI/AN population. For these conditions, improved health outcomes are likely to take several or many years before they are realized. Thus, initially it will be a significant challenge to stop the escalation of disease mortality and morbidity evident from the most recent data presented in Section 1.2 of this document.

This plan and its FY 1999 and 2000 predecessors represents significant efforts over the past three years by the IHS and its diverse stakeholders in which a " bottom-up" approach to budget formulation and GPRA performance planning has been used. This approach was adopted to support the Indian self-determination process and honor the government to government relationship that exists with tribes. Beginning with the development of the FY 1999 budget and Performance Plan, regional meetings were held to outline the GPRA and budget formulation process for all IHS Area Formulation Teams.

These Area teams then provided representatives of their local programs the opportunity for input and review of the Area recommendations, which were then compiled. For the past two years Area Formulation Team representatives then came together along with tribal leaders and representatives from several Indian organizations to merge and reconcile the Area recommendations into a single IHS set of budget priorities.

Using these identified budget priorities, a multidisciplinary team of stakeholders that included health program, budget, and information technology experts, epidemiologists, and IHS and tribal managers developed this plan. In addition to the identified budget priorities this plan reflects the context of both the Department of Health and Human Services (HHS) Strategic Plan, the President's and Secretary's initiatives, and the *Healthy People 2000/2010* goals and objectives.

This performance plan and the requested budget that underpins it, represent a cost-effective public health approach to reduce the health disparities that prevail for AI/AN people. By most objective measures of efficiency and effectiveness in addressing health problems, we have been and are frugal and have a proud history of accomplishments that document the achievement of significant results long before it was required by law. With reasonable support over the next decade, in partnership with our stakeholders, we will accomplish even more.

1.1 Agency Mission and Long-Term Goals

The Indian Health Service (IHS) has the responsibility for the delivery of health services to Federally-recognized American Indians and Alaska Natives (AI/AN) through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. In 1995 a group of stakeholders charged by the IHS Director to reorganize the IHS, revised the mission and goal and added a foundation as follows:

MISSION:

The mission of the Indian Health Service, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, and spiritual health to the highest level.

GOAL:

To assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

FOUNDATION:

To uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

These three responsibilities have been integrated into the evolving IHS component of the Department of Health and Human Services (HHS) Strategic Plan for the GPRA to yield four broad IHS Strategic Objectives to guide the Agency into the next millennium. The first is essentially a restatement of the HHS Strategic Plan Objective 3.6 *Improve the health status of American Indian and Alaska Natives*, while the remaining three strategic objectives represent the means to achieve the first:

Strategic Objective 1: Improve Health Status

To reduce mortality and morbidity rates and enhance the quality of life for the eligible American Indian and Alaska Native population.

Strategic Objective 2: Provide Health Services

To assure access to high quality comprehensive public health services (i.e., clinical, preventive, community-based, educational, etc.) provided by qualified and culturally sensitive health professionals with adequate support infrastructure (i.e., facilities, support staff, equipment, supplies, training, etc.)

Strategic Objective 3: Assure Partnerships and Consultation with I/T/Us

To assure that I/T/Us, and IHS Area Offices and Headquarters achieve a mutually acceptable partnership in addressing health problems:

- *providing adequate opportunities for I/T/Us and American Indian and Alaska Native organizations to participate in critical functions such as policy development and budget formulation, and*
- *assuring that I/T/Us have adequate information to make informed decisions regarding options for receiving health services.*

Strategic Objective 4: Perform Core Functions and Advocacy

Consistent with the IHS Mission, Goal and Foundation, to effectively and efficiently:

- *advocate for the health care needs of the American Indian and Alaska Native people, and*
- *execute the core public health and inherent Federal functions.*

These Strategic Objectives are essential for the realization of our Mission, Goal, and Foundation over the next five to 10 years by setting the programmatic, policy, and management course for the IHS. They are also consistent with the most recognized approach to evaluating health care organizations in that they address the *structure, process, and outcomes* of health care delivery and provide the conceptual and philosophical framework for the performance indicators outlined in this annual performance plan.

During FY 2000, the IHS and its stakeholders will identify specific long-term quantifiable health status and health care measures that will serve to provide benchmarks for focusing improvement efforts for the future. In essence, this effort will establish quantified targets for Strategic Objectives 1 and 2. While the IHS is waiting to review and consider the final recommendations from the Healthy People 2010 efforts, preliminary work with stakeholders has identified several likely health measures to set long-term improvement targets for the AI/AN population that include:

- years of potential life lost
- accident/injury death rate
- diabetes prevalence and death rates
- infant death rate
- immunization rates for children and adults
- Quality of Life Index
- cancer survival rate
- obesity prevalence rate
- suicide rate
- rate of children free of dental decay and adults with 20 or more functional teeth
- prevalence of substance abuse (i.e., alcohol, drugs, and tobacco)
- percent of homes with adequate water and sewage facilities

Clearly making measurable improvements in these health measures is mission critical because they represent many of the areas of greatest disparities between the AI/AN people and the U.S. general population. Eliminating only these disparities within even 20 years would represent a public health accomplishment of unparalleled magnitude in recent history.

1.2 Organization, Programs, Operations, Strategies and Resources

The IHS is the Operating Division (OPDIV) within HHS charged with administering the principal health program for the eligible AI/AN population. The IHS provides comprehensive health services through its I/T/U system of facilities and programs. Many of the people served by the IHS live in some of the most remote and poverty stricken areas of the country, and these health services represent their only source of health care. In terms of magnitude, the I/T/Us provide health services to over 1.3 million people through 151 service units composed of 554 health care delivery facilities, including 49 hospitals, 218 health centers, 7 school health centers, and 280 health stations, satellite clinics, and Alaska village clinics.

Within this system, Indian tribes deliver IHS-funded services to their own communities with about 42 percent of the IHS direct services budget in 13 hospitals, 160 health centers, 3 school health centers, and 236 health stations, satellite clinics, and Alaska village clinics. Tribes who have elected to retain the Federal administration of their health services at the present time receive services with about 58 percent of the IHS direct services budget in 36 hospitals, 58 health centers, 4 school health centers, and 44 health stations and satellite clinics. The range of services includes inpatient and ambulatory care, extensive preventive care, and a diversity of health promotion and disease prevention activities.

In addition, various health care and referral services are provided to Indian people away from the reservation settings through 34 urban Indian health programs. It is estimated that almost 60 percent of all AI/ANs now reside in or near urban centers rather than reservations and available evidence suggests they have considerable health care needs. The Contract Health Services program is an integral part of the IHS system for purchasing services from non-IHS providers to support, or in some cases in lieu of, direct care services. Contract Health Services represents about 18 percent of the IHS Budget and is distributed to IHS and Tribal programs at the same relative percentage as direct services funding (i.e., IHS = 59%, Tribal = 41%). In FY 1998, the IHS Fiscal Intermediary processed approximately 350,000 payment claims.

Since its inception in 1955, the IHS has demonstrated the ability to effectively utilize available resources to improve the health status of the AI/AN people. This contention is supported by dramatic improvements in mortality rates between 1972-74 and 1994-96, including:

- maternal mortality reduced 78% (27.7 to 6.1 per 100,000)
- tuberculosis mortality reduced 82% (10.5 to 1.9 per 100,000)
- gastrointestinal disease mortality reduced 76% (6.2 to 1.5 per 100,000)
- infant mortality reduced 66% (22.2 to 7.6 per 100,000)
- accident mortality reduced 57% (188.0 to 80.6 per 100,000)
- pneumonia and influenza mortality reduced 50% (40.8 to 20.2 per 100,000)

When compared with the U.S. general population, the IHS achieved these improved outcomes in the face several complicating factors including:

- insufficient per capita expenditures for health care
- limited availability of providers (e.g., half the physicians and nurses per capita)
- higher costs for providing health care in isolated rural settings (loss of economies of scale)

- lack of facilities in numerous locations and many outdated existing facilities (i.e., average age of IHS facilities is 32 years in comparison to 9 years for the private sector)
- lower utilization of health care services (e.g., 25% annual utilization of dental service for AI/ANs compared to about 60% for US population overall)
- significantly higher health care needs because of poor health status (significantly higher rates of diabetes, alcoholism, injuries, oral diseases, and overall death rate)
- high unemployment, poverty, substandard housing, and other recognized contributing factors to reduced health status

While overall outpatient visits have steadily increased with the AI/AN population growth of over two percent annually, decreases have occurred in access to non-urgent primary services which include:

- 20% decline in well child services between FY 1992 -96
- 14% decline in physical exams between FY 1994 -96
- 18% reduction in people receiving dental services between FY 1994 -96
- 28% reduction in water fluoridation compliance between FY 1994 -96
- 79% increase in denials of claims from health care contractors between FY 1993- 96

In this context, the increasing demand for urgent care has reduced the capacity of the IHS to provide the primary services that are critical to long-term health maintenance and improvement. Of greatest concern are the most recent mortality data (FY 1996) available from the National Center for Health Statistics adjusted for miscoding of AI/ANs. These data document an upward trend in deaths of AI/AN people for the period of 1994-96 compared to the period 1992-94 from cancer, diabetes, cerebrovascular disease, suicide, alcohol, and HIV/AIDS. The net result of these categorical increases is an overall increase in death rate for AI/AN people from 690 per 100,000 population for the period 1992-94 to 699 per 100,000 population for the period 1994-96. Given that the U.S. general population mortality rate declined during these comparable time periods from 513 per 100,000 population to 503 per 100,000 population, it is clear the health disparity gap relative to AI/AN mortality is worsening.

Given these trends and challenges, the IHS and its diverse stakeholders have been reorganizing the IHS and are continually developing alternative methods to assure more efficient health programs and administrative support to Indian communities. The redesign efforts emphasize patient care; strengthening government to government relations; streamlining administration and management; quality support services to field-based health care activities; diversification of operations; facilities staffing expansion; and fair treatment of employees. This performance plan supports and provides quantifiable measures for each of these priorities.

The budget supporting this performance plan proposes a multidisciplinary approach that crosscuts programs key to improving health status and addressing complex health problems caused by chronic diseases and harmful behavioral health practices (see Executive Summary on page 14 to enhance the integration of clinical expertise from medical, behavioral health, and community health staff in order to address the top health problems identified by the I/T/Us. The community-based public health model is strengthened by emphasizing prevention strategies throughout the clinical service activities as well as expanding the community health programs and supporting partnerships with community resources such as public safety programs, schools, and other community based organizations.

The first priority in the budget request is to improve access to basic health services for AI/AN people. In this context, the request addresses the multiple health issues affecting the AI/AN population and is the beginning of a long-term plan to assure improvements in the health of the AI/AN population. The proposal targets the health problems identified as highest priorities by the I/T/Us and responsible for much of the disparity in health status for the AI/AN population. These include alcoholism and substance abuse, diabetes, cancer, mental health, elder health, heart disease, injuries, dental health, maternal and child health, domestic violence, infectious diseases, and sanitation.

The support for public health infrastructure is also fundamental to these initiatives. These investments will support surveillance, prevention and treatment services and are based on “best practices” defined in health literature. This approach is consistent with the Presidential Executive Order directing Federal entities to employ such industry standards. Many of the IHS performance indicators for "treatment" and "prevention" represent our commitment to this process.

An essential component of supporting access to services and improving health status in the long run is to assure that there are adequate facilities and equipment for the provision of health services. With average age of IHS facilities being 32 years, the IHS must assure an efficient, safe, and pleasant environment for the provision of services by ongoing maintenance, repair, renovation, and replacement of health care facilities. The funding request for these functions is underpinned by performance measures in the section addressing Capital Programming/Infrastructure.

Also critical is the provision of adequate contract support services to the tribal health delivery system. These requested funds will provide for tribal communities to assure that there are utilities, training, clerical staff, administrative and financial services needed to operate health programs. This investment is consistent with the Administration’s commitment to expanding tribal participation in the management of the programs and the principles of the Indian Self-Determination Act.

Another target of the FY 2001 funding request is water and sewer systems for new and existing homes at the community level to support further progress to be made in preventing infectious diseases and improving the quality of life and is thus specifically addressed in this plan. This performance plan backs this request with a specific performance measure as part of the Capital Programming/Infrastructure section of this document.

In summary this performance plan and budget request represents an initial increment required to move forward to make improvements in the health status of AI/AN people and ultimately reduce the significant health disparities they face.

1.3 Partnerships and Coordination

Given the magnitude of AI/AN health disparities and recent trends in IHS funding, it is critical that the IHS identify and collaborate with all available outside organizations with the capacity, capability, and interest to assist in addressing these diverse health problems. Our resolve to develop this cross-cutting network is evident by IHS Performance Indicator 35 that commits to expanding our collaborative network.

It is important to acknowledge that in most cases this assistance will not consist of providing health care personnel or resources to provide basic health services to AI/AN people. The exception to this pattern has been agreements made with military health units or medical and other health profession schools who make available health care providers for short periods of time. Thus, it is unlikely that the IHS will make significant gains in expanding access to services by expanding the collaborative network that result in adding significant numbers of providers to I/T/U system. However, the significant benefits that have been realized through these collaborations warrant further efforts to expand this network.

Most agreements and collaborative partnerships the IHS has negotiated relate to gaining assistance in developing or disseminating new health care and/or surveillance technologies or securing a variety of training and technical assistance support for I/T/U providers. In addition, IHS has been collaborating with HCFA to improve the annual rate setting process for Medicare and Medicaid. Over the last few years, HCFA has assisted IHS in the development of annual Medicare Cost Reports and this has served to improve the annual rate setting. Furthermore, improved rate setting has resulted in increased Medicare and Medicaid collections.

The following examples of recent and developing collaborative activities met one or more of the following criteria:

- clearly presents the true influence that the Federal agency and its programs wield
- shows program coordination as key elements of interest with GPRA implementation to achieve performance goals
- clarifies roles of the agency, related Federal agencies, and performance partners
- demonstrates agency strategy to coordinate efforts of crosscutting programs-activities, complementary and common
- documents uniqueness of the agency and its distinguishable contributions, complementary and common
- presents agency plans for eliminating duplication and overlap

PROGRAM COORDINATION BY PARTNER

WITHIN DHHS:

ACF/Head Start Bureau

- agreements for IHS to provide health related training and technical assistance to AI/AN Head Start programs
- collaboration in joint Head Start- IHS Obesity Prevention Initiative(see Indicator 25 on page 62)

AHRQ (FORMERLY AHCPR)

- collaborated to develop a Quality Measurement and Improvement fellowship position in AHRQ
- collaborating on incorporating IHS inpatient data in AHRQ's Healthcare Cost and Utilization Project database
- collaborated in supporting the December 1999 "Crafting the Future of American Indian Health" conference in San Diego to assist tribe in developing collaborations and partnerships with medical and university communities
- collaborating on working together to provide support as IHS restructures its research program
- collaborating on the development of a Medical Expenditure Panel Survey with the National Center for Health Statistics (NCHS)

ASSISTANT SECRETARY FOR PLANNING AND EVALUATION (ASPE)

- supported the role of HHS with the White House Mental Health Conference to meet the mandate of the 1999 State of the Union address of President Clinton

CDC

The IHS and CDC have collaborated in addressing a diversity of health issues over the past decade. As a result, the IHS and CDC now annually develop an umbrella agreement and work plan that currently addresses:

- cancer and cancer surveillance
- smoking and tobacco control
- diabetes and the Diabetes Prevention Center in Gallup, NM, which is a jointly sponsored initiative contracted to the University of New Mexico
- reproductive health/sexually transmitted diseases
- immunizations/vaccines
- injury prevention
- hantavirus surveillance and study

Other agreements with CDC address:

- chronic disease prevention and health promotion activities
- hepatitis prevention and control
- nutrient database for AI/AN foods as a component of the National Food and Nutrient Analysis program
- assignment of a public health advisor for vaccine-preventable disease control

In addition, the IHS and CDC are in the process of formalizing new agreements for FY 2000 addressing support for water fluoridation and exercise/fitness demonstration projects that are represented in the IHS FY 2000 and FY 2001 Performance Plans.

FDA

- assistance and cooperation in reducing radiation exposures; analysis of radiation use in diagnostic radiation operations; education and training on radiation health and safety and exchange of information on medical devices

HCFA

- establish a Liaison to advise HCFA managers on policy information respective to health care program's administered by the IHS and Tribal Governments
- established IHS representative on National Medicare Education Program Task Force
- established HCFA personnel assignments to Indian Health Care issues at all Regional Offices and at the Baltimore Office
- negotiated new Medicare/Medicaid rates for IHS
- collaborated on a number of legislative initiatives
- collaborated on IHS/HCFA eligibility listings of beneficiaries through Beneficiary Eligibility Workgroup
- collaborated on Home Health Care through workgroup
- collaborated through HCFA/IHS Steering Committee to discuss major issues affecting the agencies
- Collaborated with HSRA and IHS on "Dear State Health Official " letter announcing Department policy to exempt AI/AN children from cost sharing provisions under the SCHIP
- IHS representative on HCFA APC Workgroup
- collaborated on Business Office conferences and TECH Fair
- collaborated on reimbursement issues across state lines with our Regional Treatment facilities.

HRSA

- provide support for PHS Primary Care Policy Fellowship program to bring 30 Federal and private sector primary care leaders to enhance their capabilities to advance the primary care agenda at the local, state, and national level. It also sponsors a mid-year Primary Care Networking Conference for collaborations.

NIH

- NIH/NCI for research into etiology of cancer, incidence and prevalence among Northwest American Indians and Alaska Natives
- National Institute for Dental and Craniofacial Research - treatment of Native Americans with Non-Insulin Dependent Diabetes Mellitus and Periodontal Disease
- National Institute of Diabetes & Digestive Kidney Diseases - comprehensive evaluations of diabetic renal disease in the Pima Indian population and to provide for training in diabetes care
- provide engineering services to Rocky Mountain Laboratory Upgrade Project
- National Institute of General Medical Sciences -support various IHS grant projects

OMH

- support Tribal Colleges and Universities/HHS Annual Conference

OWH

- workshops for women's health issues

SAMHSA

- co-sponsor SAMHSA's Second National Conference on Woman, Life Pathways: Woman Healing, Thriving, and Celebrating

OTHER FEDERAL AGENCIES

DOI/BUREAU OF INDIAN AFFAIRS

- provide technical assistance and training for background checks of employees of tribal health programs
- addressed ongoing adolescent suicide problems among AI/AN youth
- co-sponsored June 1999 National Youth Conference with BIA and ANA.

DOJ

- develop capability to photographically document and electronically transmit photographs of injuries sustained by crime victims.

EPA

- coordinate activities of both agencies in a manner that promote the mutual interests, cost-efficiency, and overlapping responsibilities to design and construct wastewater treatment projects on American Indian reservations using cross-cutting services and resources.
- Tribes are provided the opportunity for consultation on projects and may choose to administer their project through grant applications with IHS and EPA providing the technical guidance and support.

U.S. ARMY MEDICAL COMMAND

- assist the IHS in obtaining professional services from dentists and dental hygienists

USDA

- agreement for WIC services for Head Start Indian children to provide basic nutrition food items to ensure health physical development of children between ages 1-5 years old

VA

- Nationally, IHS is collaborating with VA on targeted data systems and credentialing.
- Native American veterans registered with VA will be targeted for VHA services as a result of identification of under-served areas of Indian country where Native Americans reside
- Many local IHS facilities have care agreements and pharmaceutical supply agreements with nearby VA facilities.

OTHER PROGRAM COORDINATION BY SUBJECT

IHS Director's Children and Youth Initiative

The IHS Director is currently spearheading a Domestic Policy Council multi-departmental initiative for AI/AN children and youth around two themes:

1. Ensuring a safe and healthy home and community
2. Ensuring personal development within the context of developing communities

Response thus far has encouraging with active participation from HUD, DOI, DOA, DOT, and several HHS OPDIVs. The ultimate goal for the initiative is to improve the status of AI/AN children and youth relative to indicators reflecting the two themes. The approach is to collaborate with agencies that serve AI/AN people to improve coordination of services and increase access to services for AI/AN communities (including urban areas). Included in this

effort is the drafting of an Executive Order to redirect policy and support needed legislative changes. In addition, the initial workgroup of this initiative embraced the importance of agencies documenting their commitment to the initiative through identifying appropriate specific GPRA performance indicators.

Obstetrics and Gynecology Training and Technical Assistance from the American College of Obstetrics and Gynecology (ACOG)

- ACOG Fellows in Service Program recruits college ob/gyn doctors for short term assignments in IHS facilities to fill in while our IHS physicians are on leave, maternity leave, educational training, etc. There are approximately 12-15 assignments that occur during each year
- The ACOG Committee on American Indian Affairs conducts OB/GYN Quality Assurance site visits to 2-3 IHS facilities each year
- ACOG Post-Graduate Courses on Neonatal and Gynecologic Care course is built around and focuses the training to the environment/setting of IHS facilities and services. Approximately 100 doctors, nurses, physician assistants, and others attend annually to keep updated with OB/GYN standards.

Injury Prevention

The mission of the IHS Injury Prevention Program is to decrease the incidence of severe injuries and death to the lowest possible level and increase the ability of tribes to address their injury problems. The IHS has initiated an aggressive public health attack to prevent traumatic injury. Primary emphasis is directed to the greatest cause, motor vehicle crashes, and to the most common risk factors, lack of use of safety restraints, abuse of alcohol, and poor road conditions in rural areas. Other projects are focusing on preventing injuries to the elderly as a result of falling, the prevention of burn and fire injuries that occur in the home, the use of motorcycle and bicycle helmets to reduce traumatic brain injury, and drowning prevention.

To accomplish their mission, the IHS Injury Prevention Program has formed partnerships with many government and non-government agencies. Formal Interagency Agreements exist between IHS and the National Center for Injury Prevention and Control, the U.S. Fire Administration, and National Highway Traffic Safety Administration. Program staff work with many other agencies and groups including the following; the National Safe Kids Campaign, the Consumer Product Safety Commission; National Safety Council's Air Bag Safety Campaign; Bureau of Indian Affairs' Law Enforcement Services and Division of Highway Safety; American Academy of Pediatrics, Committee on American Indian & Alaska Native Child Health; Federal Highway Administration; HRSA's Division of Maternal & Child Health; The Johns Hopkins University; Harborview Injury Prevention Research Center; and private foundations.

1.4 Summary FY 1999 Performance Report: Accountability through Performance Measurement

A History of Commitment to Performance

The IHS has practiced performance management and performance measurement for almost a half of a century. We have demonstrated this commitment by being pioneers in quality assurance in health care, health services resource planning, the application of information technology to health care, and the use of alternative providers and the application of the Community Oriented Primary Care approaches to health care delivery. These efforts and many others were essential to achieving the mostly unspoken and unwritten commitment adopted by most I/T/U staff to accomplish the most good (i.e., improved health), for the largest number of people, at the lowest possible cost, and in a manner that is acceptable to the consumer and the provider. As presented in Section 1.2, between 1972 and 1994, these efforts resulted in dramatic improvements in mortality rates for AI/AN population.

During our early years the results of our efforts were published as reports and journal articles from across the healthcare disciplines, often in collaboration with outside researchers and evaluators. While this collaborative approach is still used today, since 1984 the results of these efforts in terms of the health services provided, health outcomes, and other relevant demographics of AI/AN people have been annually reported in the publication *Trends in Indian Health*. In 1990 a second annual report, *Regional Differences in Indian Health*, was added to provide similar information specific to each of the 12 IHS Areas.

More recently the IHS has prepared the *IHS Accountability Report* for each fiscal year since FY 1996, which overviews health program accomplishments and management accountability and includes the annual report on the financial statement audit. While performance management and performance measurement have come a long way with the implementation of GPRA, it represents a new challenge but a familiar concept for the IHS.

FY 1999 Performance Summary

The FY 1999 performance report is included with each indicator in Part II of this document. The data are summarized in tables that precede each set of performance indicators and are elaborated in greater detail under the description of each individual indicator. The Y2K efforts over the past year and recent conversion to new hardware and software at our data center diverted considerable attention away from normal health care data managing activities. As a result, when preliminary data runs were recently made, some of the new conversions routines were not completely functional and a significant volume of data were missing from many field sites. Despite these difficulties, with considerable effort the IHS is able to report on 20 of the 27 indicators. Of these 20 indicators, 16 were attained completely, four were partially attained, and one was not met.

While all of the IHS process indicators were met to at least some degree, the most challenging and most important measures in terms of our mission are the indicators that address access to critical health services. In this light, it is of great concern that the indicator addressing the immunization of children was not met for FY 1999. Similarly, while the dental indicators addressing access to care (Indicator 12, page 45) and dental sealant coverage in children (Indicator 13, page 46) were met, they do not represent increases in services for AI/AN people.

Furthermore, while data or analyses of data are not yet available for the indicators that address four indicators relating to services for diabetic patients (available by August 2000), it is uncertain whether these will be achieved.

This projection is largely based on growing difficulties in the recruitment and retention of health professionals, particularly dentists, pharmacists, and nurses, which have approached 20% vacancy during FY 1999 and are continuing in FY 2000; the highest rates in our history. Indeed, vacancies of this magnitude will continue to make the achievement of access-related performance measures very difficult. A detailed analysis of this problem is presented in the section that follows addressing external factors influencing success.

Despite these challenges, the implementation of GPRA in the IHS has resulted in some unanticipated benefits that are likely to contribute to future success. First, the GPRA/Budget Formulation process has increased collaboration and understanding of public health and budgeting across the diverse IHS stakeholders. The process of addressing these issues beginning at the local level and moving up has aligned and mobilized tribal leaders and consumers about funding issues that address significant public health problems. In this process health program staff have learned more about the IHS budget process and budget/finance staff have learned more about public health. But probably of most importance, tribal leaders and consumers have had the opportunity to have dialogue about the "big picture" of Indian health and learn more about both public health and budgeting.

This new knowledge appears to have resulted in improved cooperation across the diverse I/T/U network. As a result, I/T/U leaders are using this knowledge within the political system to speak in less parochial and more unified voices supported by data, to justify funding requests. Furthermore, a growing number of tribally managed programs that legally do not have to participate in GPRA are not only participating, but encouraging other tribal programs to do likewise. We are hopeful that the collaborative reflection on our successes and challenges from the FY 1999 GPRA process will serve to improve our performance in the future.

External Factors Influencing Success

A variety of external factors have functioned as powerful determinants in the level of attainment of the FY 1999 Performance Report and will continue to influence our success in future performance reports. It is important to acknowledge that for many of these factors the distinction between what is external versus internal is often blurred. However, making this distinction is a critical element in successfully addressing them.

Recruitment and Retention of Health Care Providers

As acknowledged in the previous section, vacancy rates for some health care providers are at the highest level in IHS' history and are directly related to difficulties in both the recruitment and retention of these providers. The reasons for these recruitment and retention difficulties are complex and include both external factors as well as factors within the I/T/U settings. The broader external factors are the growing debt levels for health professionals leaving school, coupled with increasing earning potential in the private sector as a result of a healthy economy and relative shortages of these health professionals. The factors within the IHS context include relatively poor salary parity between the Federal systems and the private sector, isolation and a lack of urban amenities in many reservation settings. Furthermore, limited spousal employment

opportunities, ancillary support, and clinical space to address an ever-increasing patient load, have also contributed to recruitment and retention difficulties.

These local factors coupled with diminished professional support from downsized Areas and Headquarters, which includes reduced career development and training opportunities, have resulted in an a decrease in morale of I/T/U providers. Objective indicators for this trend include the relatively low score of the IHS in the 1998 and 1999 HHS surveys which define the Human Resource Management Index from the Department as a whole and for each OPDIV. This annual process is based on a survey of a sample of employees from each HHS agency and has been designed to assess several recognized components of the "quality of work life." In addition to this measure, there has been a significant increase in EEO filed complaints over the past few years within the IHS.

Thus, the net effect of these trends is to compound the retention problem because the staff are affected by diminished support and overwhelmed by the patient load. For consumers, the waiting times for appointments increase and complaint rates increase. This can result in staff becoming discouraged and resigning, patients giving up trying to access the system for health care needs except emergencies, and access to services such as well-baby, cancer screening, dental care, or diabetes control in effect become reduced.

The IHS is committed to improving its performance in the recruitment and retention of well qualified health care providers and the FY 2000 and 2001 Budget Requests and Performance Plans strategically address this problem. Activities directed towards this end include:

- expand web-based recruiting efforts
- expand use of alternative Federal pay structures to address pay parity issues
- expand the loan repayment program and make it more flexible for I/T/U use
- develop alternative mechanisms to support health disciplines in partnership with tribes and tribal organizations
- enhance quality of work life (QWL) through greater adoption of HHS QWL policies and enhanced leadership training

The Role of Poverty

The relationship between poverty and higher levels of morbidity and mortality for both acute and chronic diseases and conditions has been documented worldwide. In fact, many of the racial and ethnic disparities in health status disappear when analyses control for education and socioeconomic status. Across Indian Country, mortality and morbidity rates generally follow the general economic indicators such a socioeconomic status, employment rate, and also educational level. As noted in the introduction of this document, the IHS serves several of the poorest communities in the country that also have the lowest life expectancy rates.

While increasing access to comprehensive health services over time will reduce both mortality and morbidity to some degree in these situations, health services alone are not likely to eliminate the huge health disparity gap that now exists, unless the other complex factors contributing to poverty are also addressed. However, it must be acknowledged that the current limitations on access to many essential services are contributing not only to poor health but also to poor economic conditions. Indeed, poor health status should be viewed as both a cause and an effect of poverty.

We offer an example of how powerful even relatively mundane and non life-threatening health problems can be when they are extreme. Between 1988 and 1991 the IHS Dental Program participated in the World Health Organization sponsored International Collaborative Study of Oral Health Outcomes. Data were collected on the Lakota Sioux Indian people on the Pine Ridge and Rosebud Reservations in South Dakota and on Navajo people in the northeast corner of the Navajo reservation in Arizona and New Mexico. Other study sites include Baltimore and San Antonio in the United States and Latvia, France, New Zealand, and Japan. The study included calibrated and standardized oral examinations with assessments of disease rates and treatment needs and a detailed patient interview that included a history of dental experiences and problems.

The oral health examination corroborated findings from IHS surveys that the oral conditions of Navajo and Lakota Indian people were very poor with disease rates two to four times that of all other study sites. Findings from the studies patient interview that assessed the impact of oral health on a variety of quality of life measures revealed the following alarming findings:

- one third of school children report missing school because of dental pain.
- 25% of school children avoid laughing or smiling and 20% avoid meeting other people because of the way their teeth look.
- as a consequence of dental pain, almost a quarter of the adults are unable to chew hard foods, almost 20% report difficulty sleeping, and 15% limit their activities (i.e., work and leisure).
- three quarters of the elderly experience dental symptoms, and half perceive their dental health is poor, or very poor and are unable to chew hard food.
- almost half of the adults avoid laughing, smiling, and conversations with others because of the way their teeth look.

These "quality of life measures" were 200 to 400 % more severe for the Indian study respondents than those from any other sites including Baltimore and San Antonio. Clearly, conditions of this magnitude represent significant disparities in health status and are not just dental problems, but have significant social, psychological, and economic consequences on peoples' self-esteem and their ability to learn, secure employment, and reach their full potential. When such dental conditions are superimposed on top of other prevalent conditions normally considered far more severe such as diabetes, alcoholism, and family violence, a person's capability to achieve self-sufficiency is seriously compromised.

There is little doubt that in many AI/AN communities health status is contributing to the economic hardship they experience. It is also true that improved health care alone cannot make up for the lack of opportunities for economic development. Some tribes are making significant progress in this process and many of these are the ones who have exercised their option under the Indian Self-Determination legislation to manage their own health programs. While the IHS is not an economic development organization, we are committed to assuring that our available resources are used effectively to minimize the negative effects of poor health status on the general socioeconomic well-being of AI/AN communities. Furthermore we are working to collaborate with the BIA, the Agency for Native Americans, and with other organizations with the capacity to assist in economic development. Our success in improving health status in FY 1999 and many years to come will be strongly influenced by the overall success in addressing poverty in Indian Country.

A Lack of Cost-Effective Interventions for Chronic Diseases

A major challenge the IHS must address is how to provide health care in the face of increasing mortality and morbidity rates for diseases such as alcoholism, diabetes, and cancer that represent extremely costly conditions to treat. Of these problems, perhaps diabetes represents the greatest economic threat to the IHS. Within the I/T/U system are communities with the highest diabetes prevalence in the world with many other communities showing accelerating increases annually. Although we are collaborating with CDC and the University of New Mexico to develop preventive approaches, at this point in time, there are no proven large-scale educational or medical interventions known to reduce the prevalence of this condition in populations.

Until a preventive technology is developed, we are faced with the costly medical management of diabetics that is currently estimated in the diabetes literature at \$5000 to \$9000 per patient per year. The IHS is funded at approximately \$1350 per person per year with Medicare/Medicaid, private insurance collections and out of pocket expenditures adding an estimated \$500-700 more. Thus, AI/AN people are funded at approximately \$2000 per person annually compared to with almost \$4000 for the U.S. general population. In communities where the diabetes prevalence is approaching 40-50 percent, the entire available per capita funding could be completely consumed in treating diabetes, leaving nothing for alcoholism, cancer, injuries, oral health, prenatal care, and well-baby/immunizations to name only a few.

Given these economic realities, the I/T/Us are faced with difficult choices in assuring access to essential health care. While there are always ways to improve efficiency and effectiveness and "do more with less," at least in this country, there are no private or public health systems that have set benchmarks for effectively addressing diseases problems of this magnitude with the resources the IHS has had available. It appears decidedly easier to show a profit in the health care industry than to improve the health of the poorer segments of the population. We contend that since our inception in 1955 to the early 1990s, the IHS has set the benchmarks for rural health care efficiency and effectiveness.

Clearly our long-term success in improving the health of the AI/AN population will be strongly influenced by the development of major cost-effective treatment and/or preventive technologies for addressing the many health conditions AI/AN people experience at high rates.

Third Party Collections

The IHS has established a priority to fully maximize third party collections for delivery of health care services. This priority was established in recognition that increasing collections is a critical element to maintaining and improving the delivery of health services to the IHS service population. Over the last few years, IHS has significantly increased its third party collections, which, have served to significantly boost the I/T/U's ability to improve the quantity and quality of its health care services being provided to its population. However, changes in legislation and

HCFA policy at the national or at the state level could affect current reimbursement collection levels and IHS' ability to maintain current service levels. For example, we have been working with HCFA to resolve several reimbursement issues regarding the States implementation of the Children's Health Insurance Program. One state has refused to reimburse IHS for inpatient physician services for CHIP eligible children.

Transitions to Tribal Management

The rate of transition to tribal management of health programs has and will continue to represent a significant challenge to the IHS. This transition toward tribal management of health programs superimposed on recent funding constraints has required Area Offices and Headquarters to downsize significantly. An unfortunate side- effect of this downsizing has been the loss economies of scale and reductions in the IHS public health infrastructure.

Furthermore, the Agency's ability to meet inherent federal functions including the GPRA has been reduced. However, there is also evidence that the transfer of resources and management control to tribes has freed them to innovate, develop alternative resources, find new mechanisms for building facilities, and enhance patient care, which ultimately will improve outcomes. The level of success tribes are achieving is clearly linked to IHS funding and particularly contract supports funds. What is still not completely clear at this time is at what level tribal programs will participate in GPRA performance measurement, given that it is voluntary based on current regulations. While a growing number of tribal programs have expressed a commitment to submit data for GPRA in response to our active marketing of its importance, some have expressed resistance based on a belief that it represents an unfunded and not required activity that diverts resources away from patient care.

Indeed the IHS is in a challenging position with the responsibility of including tribal programs in performance reporting, but lacking the authority to require tribes to submit their data. Despite these challenges the IHS remains committed to tribal self-determination and to performance management and views both as essential to the realization of our Mission and Goal.

PART II - PROGRAM PLANNING AND ASSESMENT

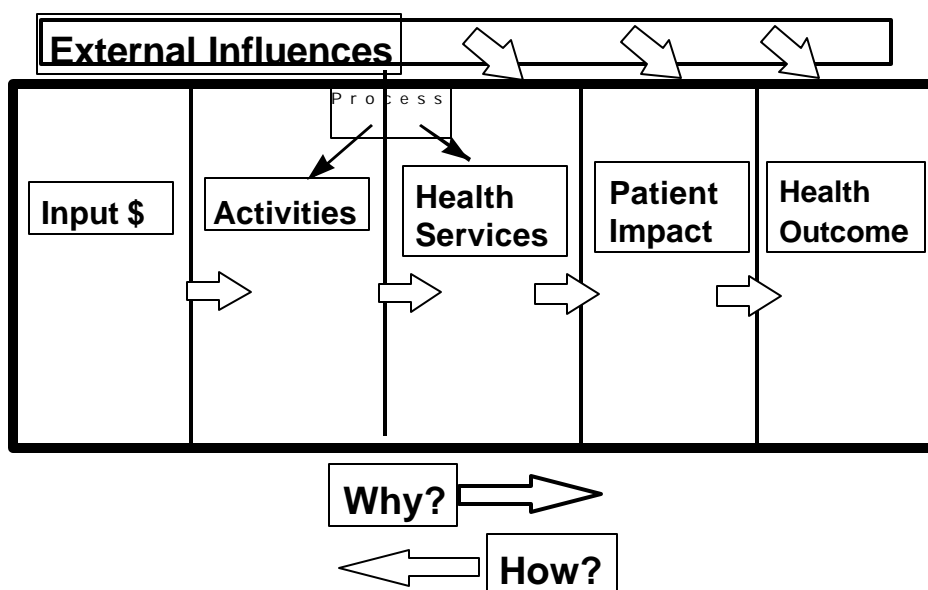
It must be borne in mind that the tragedy of life doesn't lie in not reaching your goal. The tragedy lies in having no goal to reach. It isn't calamity to die with dreams unfulfilled, but it is a calamity not to dream. It is not a disaster to be unable to capture your ideal, but it is a disaster to have no ideal to capture. It is not a disgrace not to reach the stars, but it is a disgrace to have no star to reach for. Not failure, but low aim is sin.

Benjamin Mays

Introduction and Rationale

The diagram that follows has been used the past three years to explain the GPRA process and shows that it is essentially the same as the public health approach the IHS has long followed in health planning and evaluation. The logic of this model links resources to activities or “process” (both support and direct health services) which leads to reductions in risk factors for diseases and conditions (i.e., impact) and over an extended period of time results in improved health outcomes. The model also depicts how external influences such as economic status (see Section 1.4, *The Role of Poverty*) isolation, or social norms can have powerful effects on the success of interventions, particularly in addressing lifestyle related health outcomes.

The Public Health/GPRA Approach



In light of this conceptual model, three broad categories of indicators are of relevance.

Process Indicators:

Indicators that assess the quantity or quality of activities that have the potential to contribute, at least indirectly, to reduced mortality or morbidity in the population over time.

Process indicators include activities such as the construction of clinics, identification of the prevalence of a disease or condition, implementation of consumer satisfaction surveys, and the provision of some health services (i.e., services for which the link to improved health outcomes has not been consistently demonstrated). These are important activities that may be essential to running an effective health care program, but do not in and of themselves result in improved health outcomes. The GPRA represents a process requirement, and committing to comply with these requirements represent a process indicator. (See Activities and Health Services boxes in diagram)

Impact Indicators:

Indicators that assess the quantity or quality of activities that have a scientific evidenced-based link to improved health outcomes usually by a demonstrated reduction in a recognized risk factor of mortality or morbidity in a population. These indicators are referred to as “interim outcomes” in much of the GPRA literature. They include activities such as immunizations, dental sealants, assuring safe drinking water, and cancer screenings. Over time these activities result in improved morbidity and/or mortality. Impact indicators are usually the most appropriate type of indicator for annual performance plans because they provide the most measurable link between funding and results. (see Patient Impact box in diagram)

Outcome Indicators:

Indicators that relate to assessing changes in mortality or morbidity relative to a disease or condition that program(s) address. While these indicators are the ultimate goal of health care, for many health conditions it is often years before outcome benefits are realized. Furthermore, identifying the cost of an observed outcome is often difficult or impossible in the cases of conditions that multiple providers may be addressing simultaneously while addressing other health conditions. Thus, outcome indicators are usually not the most appropriate choice for annual performance plans, but are essential to identify for long-term goals such as in the GPRA Strategic Plan. Examples include reducing the prevalence of obesity, diabetic complications or reducing the unintentional injury mortality rate (see Health Outcome box in diagram).

It is appropriate to note that general workload types of indicators such as total outpatient visits and inpatient days are not included in this performance plan because any meaningful link to health outcomes is indirect or circuitous, at best. As noted earlier, outpatient visits have grown with population growth rather than varied with level of funding. Inpatient days have been declining across the country as well as in the I/T/U care systems to control costs and neither of these measures correlate in an interpretable way with improved health status. However, these data will continue to be monitored and presented to the Department as part of the IHS annual accountability report because they are of significance in the context of expenditures and demands on the I/T/U system.

The IHS performance indicators represent sentinel indicators which are specifically focused on the most significant health problems affecting AI/ANs and/or the essential services that address them and identified by local I/T/Us. These problems include: diabetes, alcohol and substance abuse, cancer, dental diseases, mental health, heart disease, family abuse and violence, injuries, poor living environment, mental health, tobacco use, obesity, environmental hazards, and the unique health problems of elders, women and children. They all represent important links in the

GPRA/public health process directed towards outcomes. Some represent primary prevention that attempts to prevent a disease or condition before it occurs (e.g., immunizations or controlling weight to prevent heart disease or diabetes). Others are “secondary preventive” in nature in that they attempt to reduce the morbidity and mortality associated with a disease or condition after it has occurred (e.g., access to dental care or breast cancer screening). Given that there will always be ten leading causes of death, our focus is to intervene early in the processes that contribute significantly to mortality and morbidity, rather than to target end point problems such as heart attacks and stroke. This is the essence of the cost-effective public health approach that has resulted in the improvements in health status of AI/AN people over the last three decades.

We have also included indicators for improving how our consumers perceive the quality of and access to services, how employees perceive the quality of their work-life, and how our stakeholders perceive our performance in assuring adequate consultation and advocating for their needs. In addition, we have developed indicators addressing our effectiveness in building collaborative relationships with other organizations in regards to cross-cutting issues and meeting our obligations as an Agency in the Department.

These indicators do not represent the complete spectrum of activities and challenges the Agency and the I/T/Us address as part of a comprehensive public health organization. To do so would probably require several hundred indicators and require significant increases in resources just to collect the data. Consistent with the proposed GAO guidance, these indicators are limited to a vital few, represent multiple priorities, are linked to the responsible programs, and in many cases are measures we have used for many years for program evaluation. Several are focused primarily on better defining the magnitude of certain problems and improving our evaluation capability.

A major challenge in selecting indicators for a one-year plan is that many of the processes necessary for intervening in complex chronic diseases require years or decades of focused efforts to realize significant progress, even with significant resource enhancements. Therefore, only a few of these indicators directly address health outcomes, while most are incremental activities that will lead to such outcomes over time. In addition, several indicators directly embrace the principles and intent of the National Partnership for Reinventing Government and link directly with the Secretary’s Initiatives. Finally, all of the health problem related indicators support the HP 2010 goals for AI/AN, the draft HP 2010 goals, while all support the Department’s Strategic Plan.

However, it is important to acknowledge that these indicators were developed in partnership with Area and I/T/U staff and AI/AN tribal leaders with the first priority being the need to reflect the problems and strategic activities of the I/T/Us collectively. We believe this approach is essential to secure the high level of collective support we will need with our diverse and decentralized programs. Because of the diversity across I/T/Us and the freedom of tribal programs to participate in GPRA activities at their discretion, not all indicators will be of priority to all I/T/Us. Furthermore, there are activities that are not included in these indicators that will continue to be priorities, particularly health issues unique to local I/T/Us.

Budget and Program Aggregation

Because of the number and diversity of IHS health programs, these activities can be organized in many different ways. Our goal in presenting our performance measures is to the best of our ability relate performance to our budget. This is a serious challenge to the IHS for several reasons we will articulate. We have selected an aggregation approach largely based on the way our programs are managed and have selected four functional areas for the aggregation of the 24 budget categories identified in the IHS “Detail of Change Table”: 1.) Treatment, 2.) Prevention, 3.) Capital Programming/Infrastructure, and 4.) Consultation, Partnerships, Core Functions, and Advocacy. While this approach may appear to be an overly simplistic "lumping" of categories, it is important to realize that there is no aggregation or disaggregation that allows mutually exclusive activities linked to mutually exclusive health problems.

This conundrum exists because addressing most chronic diseases and problems such as diabetes, injuries, and family violence, require multidisciplinary interventions to successfully address. In such cases, there may be several health programs (and thus funding categories) simultaneously addressing a health problem such as diabetes. Confounding the issue further, these same diverse providers may be addressing other health issues such as tobacco use, blood pressure control, or mental health during the same encounter. Lastly, tribal programs, which now manage over 40% of the total IHS budget, have the legal flexibility to reprogram funding categories to meet their identified health priorities and likewise use an accounting tailored to their needs and preferences. As a result, with the exception of the facilities construction category, tribes tend to use resources based on individual tribal priorities and the link between named categories in the IHS budget and how the funds are actually used in tribal programs may not be highly correlated.

Thus, for tribal programs the aggregation issue is probably moot. For IHS managed programs, aggregation of budget categories that not only splits out activities and funding sources but also allows a valid cost accounting link to health outcomes can not be provided. In such cases, the accounting link can go no farther than services. A manufacturing type of accounting mindset taken to an extreme simply does not fit well in the context of a comprehensive public health program. Therefore, the aggregation approach we have selected seems reasonable given the limitations of any approach and that we do have the option to disaggregate these inputs if desired for a more narrowly focused look at well circumscribed programs such as dental services and public health nursing. There is no priority order to these categories and all are important in accomplishing the mission of the IHS. Table I that follows shows the relationship between the funding categories in IHS Detail of Change Table and the appendix of the “Budget of the United States” and our GPRA aggregation. A brief explanation of the components of each aggregation category precedes each set of performance indicators.

Table I

Budget Category Aggregation

<u>INDIAN HEALTH SERVICE</u>	<u>APPENDIX</u> Budget of the United States items from left column	<u>GPRA AGGREGATION</u> items from left column
Detail of Change Table		
<u>SERVICES:</u>	<u>SERVICES:</u>	
1 Hospitals & Health Clinics		1. Treatment (1,2,3,4,5,10,11,12,14,15)
2 Dental Services		2. Prevention (6,7,8,9,19b)*
3 Mental Health		3. Capital Programming/ Infrastructure (16-20)**
4 Alcohol & Substance Abuse		4. Partnerships, Consultation, Core Functions, and Advocacy (13,19a-c)***
5 Contract Health Services		
Total, Clinical Services	1 Clinical Services (1-5)	
6 Public Health Nursing		
7 Health Education		
8 Comm. Health Reps		
9 Immunization AK		
Total, Prev Hlth	2 Preventive Health (6-9)	*The Prevention category includes 35% of Environmental Health Support (19b) activities.
10 Urban Health	3 Urban Health (10)	
11 Indian Health Professions	4 Indian Health Professions (11)	**The Capital Programming/Infrastructure category includes 80% of Facilities Support (19a), 60% of Environmental Health Support (19b), and 20% of OEHE Support (19c) activities.
12 Tribal Management	5 Tribal Management (12)	
13 Direct Operations	6 Direct Operations (13)	
14 Self Governance	7 Self Governance (14)	
15 Contract Support Costs	8 Contract Support Costs (15)	
Total, Services	Total, Services	***The Partnerships, Consultation, Core Functions, and Advocacy category includes 20% of Facilities Support (19a), 5% of Environmental Health Support (19b), and 80% of OEHE Support (19c) activities.
<u>FACILITIES:</u>	<u>FACILITIES:</u>	
16 Maint. & Improvement	9 Maint. & Improvement (16)	
17 Sanit. Facil. Constr.		
18 Hlth Care Facs. Constr.	10 Hlth Care Facs. Constr. (17-18)	
19 Facil. & Envir. Hlth Sup	11 Facil. & Envir. Hlth Sup (19a- c)	
19a Fac. Support		
19b Env. Health Support		
19c OEHE Support		
20 Equipment	12 Equipment (20)	
Total, Facilities	Total, Facilities	
(20) Total, IHS	(12) Total, IHS	(4) Total, IHS

2.1.1 Treatment and Prevention Categories: Program Description, Context and Summary of Performance

Program Description and Context

Treatment and Prevention indicators have been combined in this section for several reasons including:

- the distinction between treatment and prevention is often blurred
- many health care programs provide both kinds of services
- approximately 90% of IHS resources are directed towards these activities
- monitoring for both is usually accomplished from the same data systems

In essence, prevention and treatment are our business and virtually all other activities are supportive to them. Combined they are the essence of IHS Strategic Objective 2: Provide Health Services and the means to accomplishing our Mission and Goal and IHS Strategic Objective 1: Improve Health Status. The indicators directly address the structure, process, and outcome of treatment and preventive services. While some of these measures such as the dental indicators 12 and 13 and public health nursing indicator 19 can be closely linked to the funding request, most are less directly evident in their linkage to funding because they represent activities performed by staff from multiple disciplines who address multiple health problems. For a more detailed discussion of the limitations in funding linkages with indicators, see *Budget and Program Aggregation* on page 21 and Section A.4 on page 90 in the appendix of this document.

Ultimately, our performance in treatment and prevention activities will determine our level of success in reaching our mission. While we are on track to accomplish many of the treatment and prevention targets for FY 1999, several remain in question because of the growing difficulties in recruitment and retention of critical health care providers. It is important to keep in mind in reviewing performance indicators and performance results that with the AI/AN population increasing over two percent annually, each indicator that sets a target for the percent of the population covered, service capacity must be increased over two percent just to remain at the same level of coverage. For a more detailed discussion of the issues influencing performance accomplishment see the *FY 1999 Performance Summary* section beginning on page 14. In addition, a performance summary table precedes each section of indicators and the description of each individual indicator includes an assessment of estimated performance achievement for FY 1999.

The budget category/programs that make up the Treatment and Prevention categories, along with their page reference in the budget are presented below:

Treatment Aggregation

Hospitals and Clinics - supports inpatient and ambulatory care and support services such as nursing, pharmacy, laboratory, nutrition, medical records, etc (see page IHS-28 in FY 2001 budget document).

Dental Services - supports the provision of dental care through clinical based treatment and prevention services and community oral health promotion and disease prevention activities including water fluoridation and dental sealants (see page IHS-42 in FY 2001 budget document).

Mental Health - supports community oriented clinical and preventive mental health and social services programs (see page IHS-48 in FY 2001 budget document).

Alcohol and Substance Abuse - supports the efforts of tribes in the provision of holistic alcoholism and other drug dependency treatment, rehabilitation, and preventive services for individuals and families (see page IHS-54 in FY 2001 budget document).

Urban Indian Health - supports contracts and grants to 34 urban health programs funded under Title V of the Indian Health Care improvement Act (see page IHS-94 in FY 2001 budget document).

Indian Health Professions - supports self-determination and access to health care through efforts to allow AI/AN to enter health professions, and effective recruitment of health staff by providing scholarships, loan repayment, temporary employment, and health professions recruitment (see page IHS-100 in FY 2001 budget document).

Self-Governance- provides short-fall funding of tribal self-governance compacts to avoid adverse impact to non-compacting tribes as well as supporting the Office of Tribal Self-Governance and Self-Governance Planning grants (see page IHS-116 in FY 2001 budget document).

Contract Support - provides start-up, direct, and indirect costs that occur for tribal managed programs in addition to what would have been provided under the direct provision of the program as authorized under Section 106(a) (2) of P.L. 93-638, the Indian Self-Determination Act, as amended (see page IHS-126 in FY 2001 budget document).

Prevention Aggregation

Public Health Nursing - supports the community-based Public Health Nursing program which provides treatment, counseling, health education, and referral activities carried out in such setting as homes, schools, jails, bars, and community centers in conjunction with a diversity of other health care providers (see page IHS-76 in FY 2001 budget document).

Health Education - supports activities directed towards promoting healthy lifestyles, community capacity building, and the appropriate use of health services through public health education targeted at school health, employee health promotion, community health, and patient education (see page IHS-80 in FY 2001 budget document).

Community Health Representative - supports the tribally administered program of training AI/AN community members in basic disease control and prevention. These activities include serving as outreach workers with the knowledge and cultural sensitivity to effect change in community acceptance and utilization of health care resources and use community-based networks to enhance health promotion/disease prevention activities (see page IHS-84 in FY 2001 budget document).

Alaska Immunization Program - supports the Alaska immunizations program to address hepatitis and haemophilous influenzae through collaboration with the CDC (see page IHS-88 in FY 2001 budget document).

Environmental Health Support - supports the IHS injury prevention program that coordinates and provides grants for primary preventive community-based collaborative programs using epidemiologically defined problem identification and evaluation methods (see page IHF-41 in FY 2001 budget document).

2.1.2 Treatment and Prevention: Performance Indicators

The choice of these indicators was made after considerable deliberation and "trial and error" over the past three years that has resulted in the acceptance of several selection criteria:

- they address major functional areas of our budget structure (i.e., major health programs)
- they represent I/T/U priority areas in terms of addressing health problems
- they are relatively passive to I/T/U providers in that they are extracted from existing data systems and do not add to their workload
- they do not reward under reporting of conditions (i.e., reducing complication of diabetes was dropped for this reason)
- they are evidenced-based and support recognized standards of care

While not all treatment and prevention indicators measure up to all these criteria, most come close. To make clear the ultimate intent or outcome of each process or impact indicator, each begin with a statement of intent followed by the intervention and target that will contribute to this intent. However, it is important to acknowledge that for many indicators a measurable change in the ultimate outcome is not likely to be seen in the one year time span of the performance plan.

The data that support the treatment and prevention indicators comes from several sources but the largest number are extracted from the IHS automated information system which collects data on the services provided by IHS and tribal direct and contract programs. In addition, the diabetes treatment indicators 2-5 are extracted from the IHS Diabetes Audit that is an annual systematic audit of almost 10,000 charts. Beginning in FY 2001, these indicators will be based on three-year running averages from this audit.

The software used by IHS facilities and most tribal facilities is the Resource and Patient Management System (RPMS). Data are collected for each inpatient discharge, ambulatory medical visit, and dental visit (all patient specific) and for community health service programs including health education, community health representatives, environmental health, nutrition, public health nursing, mental health and social services, and substance abuse (all activities reporting systems). The patient-specific data are collected through the Patient Care Component (PCC) of the RPMS. For a discussion of data validation processes relative to this system and the diabetes audit, see Appendix A.1.

Lastly, these indicators directly address the Secretary's Initiative to Eliminate Racial and Ethnic Health Disparities and the President's Initiative to Eliminate Disparities in Health Status Among Americans. Further connections with other initiatives and the HHS Strategic Plan will be identified in the "Linkages" section of each indicator.

**Performance Summary Table 1:
Treatment Indicators**

Performance Indicator	FY Targets	Actual Performance	Reference
<u>Indicator 1:</u> Maintain Area age-specific diabetes prevalence rates (as a surrogate marker for diabetes incidence) for the AI/AN population.	FY 01: Maintain Data-base FY 00: Maintain Data-base FY 99: Establish baseline	FY 01: FY 00: FY 99: baseline established	P: p. 32 B: p. IHS-34 p. IHS-130
<u>Indicator 2:</u> Increase the proportion of I/T/U clients with diagnosed Diabetes that have improved their glycemic control.	FY 01: 3-year average improved FY 00: 3-year average improved* FY 99: 38%	FY 01: FY 00: FY 99: 9/00 FY 98: 35% (baseline)	P: p. 33 B: p. IHS-34 p. IHS-130
<u>Indicator 3:</u> Increase the proportion of I/T/U clients with diagnosed diabetes and hypertension that have achieved diabetic blood pressure control standards.	FY 01: 3-year average improved FY 00: 3-year average improved* FY 99: 30%	FY 01: FY 00: FY 99: 9/00 FY 98: 27% (baseline)	P: p. 34 B: p. IHS-34 p. IHS-130
<u>Indicator 4:</u> Increase the proportion of I/T/U clients with diagnosed diabetes who have been assessed for dyslipidemia.	FY 01: 3-year average improved FY 00: 3-year average improved* FY 99: 81%	FY 01: FY 00: FY 99: 9/00 FY 98: 79% (baseline)	P: p. 35 B: p. IHS-34 p. IHS-130
<u>Indicator 5:</u> Increase the proportion of I/T/U clients with diagnosed diabetes who have been assessed for nephropathy.	FY 01: 3-year average improved FY 00: 3-year average improved* FY 99: 36%	FY 01: FY 00: FY 99: 9/00 FY 98: 33% (baseline)	P: p. 36 B: p. IHS-35 p. IHS-130
<u>Indicator 6:</u> Increase the proportion of women who receive Pap screening.	<u>Pap Screening</u> FY 01: +3% over FY 00 level FY 00: +3% over FY 99 level* <u>Cervical Cancer</u> FY 99: determine incidence of cervical cancer	FY 01: FY 00: FY 99: baseline 4/00 FY 99: 8-10 per 100,000 based on 40% of AI/AN	P: p. 37 B: p. IHS-35 p. IHS-136

Performance Indicator	FY Targets	Actual Performance	Reference
Indicator 7: Increase proportion of the AI/AN female population over 40 years of age who receive screening mammography.	FY 01: +3% over FY 00 level FY 00: +3% over FY 99 baseline* FY 99: establish baseline	FY 01: FY 00: FY 99: 4/00	P: p. 38 B: p. IHS-35 p. IHS-136
Indicator 8: Increase the proportion of AI/AN children receiving a minimum of four Well Child Visits by 27 months of age and expand coverage.	FY 01: +3% over FY 00 FY 00: +3% over FY 99 FY 99: establish baseline	FY 01: FY 00: FY 99: 38.5% provisional	P: p. 40 B: p.-IHS-37
Indicator 9: Maintain the rates and intensity of follow-up for adolescents discharged from IHS supported Regional Treatment Centers (RTC) and assure abstinence.	Abstinence FY 01: +5% over FY 00 FY 00: establish baseline Follow-up Rates FY 01: FY 00 level or higher FY 00: +10% over FY 99 FY 99: establish baseline for 30 days, 6 months, and 12 months follow-up rates	FY 01: FY 00: FY 01: FY 00: FY 99: 64.5% at 30 days 55.2% at 6 months 40.9% at 12 months	P: p. 41 B: p. IHS-54
Indicator 10: Expand the percentage of I/T/U prenatal clinics utilizing screening and case management protocols for pregnant substance abusing women and advocate to expand usage.	FY 01: + 10% over FY 00 FY 00: +5% over FY 99 level FY 99: establish baseline	FY 01: FY 00: FY 99: 3/00	P: p. 43 B: p. IHS-54
Indicator 11: Improve water fluoridation compliance for Areas participating in IHS/CDC Fluoridation Surveillance Demonstration Project.	FY 01: 10% over FY 00 FY 00: 15% over FY 99 FY 99: no indicator	FY 01: FY 00: FY 99: baseline 6/00	P: p. 44 B: p. IHS-42
Indicator 12: Increase annual access to dental services for the AI/AN population.	FY 01: 25% FY 00: 23% FY 99: 21%	FY 01: FY 00: FY 99: 23% preliminary FY 98: 24.5% (baseline)	P: p. 45 B: p. IHS-42
Indicator 13: Increase the percentage of AI/AN children 6-8 and 14-15 years who have received protective dental sealants on permanent molar teeth.	6-8 yrs FY 01: +3% over FY 00 FY 00: +3% over FY 99* FY 99: 50% 14-15 yrs FY 01: +3% over FY 00 FY 00: +3% over FY 99* FY 99: 58%	FY 01: FY 00: FY 99: 38.8% FY 91: 40.1% baseline FY 01: FY 00: FY 99: 66.8% FY 91: 66.5% baseline	P: p. 46 B: p. IHS-42

Performance Indicator	FY Targets	Actual Performance	Reference
Indicator 14: Increase the % of I/T/U medical facilities with Urgent Care or Emergency departments or services that have written policies and procedures for routinely identifying, treating and/or referring victims of family violence, abuse or neglect (i.e., child, spouse, elderly).	FY 01: 80% FY 00: 70% FY 99: 60%	FY 01: FY 00: FY 99: 64% FY 98: 47% (baseline)	P: p. 47 B: p. IHS-48
Indicator 15: Expand the percentage of I/T/U programs that have implemented the use of the Mental Health/Social Services (MH/SS) data reporting system.	FY 01: +10 over FY 00 level FY 00: +10 over FY 99 level FY 99: 50%	FY 01: FY 00: FY 99: 51% FY 98: est. 40-45% baseline	P: p. 48 B: p. IHS-48
Indicator 16: Develop the specifications and implementation plan for an automated mutually compatible information system which captures health status and patient care data for Indian Urban health care programs and implement at field urban sites.	FY 01: implemented in 30% of urban programs FY 00: test in at least one site* FY 99: develop specs and plan	FY 01: FY 00: FY 99: accomplished 8/99	P: p. 49 B: p. IHS- 94
Indicator 17: Maintain 100% accreditation of all IHS hospitals and outpatient clinics.	FY 01: 100% FY 00: 100% FY 99: 100%	FY 01: FY 00: FY 99: 100% FY 98: 100% (baseline)	P: p. 50 B: p. IHS-28
Indicator 18: Improve AI/AN consumer satisfaction with the acceptability and accessibility of health care as measured by IHS consumer satisfaction survey.	FY 01: +5% over FY 00 baseline FY 00: establish baseline* FY 99: develop instrument and protocol	FY 01: FY 00: FY 99: instrument and protocol complete	P: p. 51 B: p. IHS-28
Total Treatment Funding:	FY 01: \$2,113,572,000 FY 00: \$1,931,326,000 FY 99: \$1,811,951,000 FY 98: \$1,711,018,000 * indicates revised FY 2000 measure, see Summary of Changes Table on pages 87-90		P: page # in perform. plan B: page # in budget justif.

A. FY 2001 Treatment Indicators:

Indicator 1: To support planning for the treatment and prevention of diabetes during FY 2001, maintain Area age-specific diabetes prevalence rates and identify trends in the age-specific prevalence of diabetes (as a surrogate marker for diabetes incidence) for the AI/AN population.

Rationale: Diabetes continues to be a growing problem in many AI/AN communities with rates increasing rapidly in several Areas, age at diagnosis occurring at younger ages, and no signs of decline in any Area. The impact of this disease in terms of individual and family suffering is immense, as are the treatment costs to the Indian health delivery systems. Though incidence rates of diabetes (occurrence of new cases within a certain time period) are very difficult and expensive to collect, and are only done reliably in large, population-based studies, trends in age-specific prevalence rates of diabetes can provide evidence of an increase or decrease in diabetes for a certain age group and may suggest a change in true incidence. Analysis of these trends will allow the program and I/T/U's to target prevention efforts to specific age groups in ongoing and future interventions.

Approach: The IHS Office of Public Health is responsible for overall coordination of efforts to achieve this indicator. The IHS Diabetes Program estimates diabetes prevalence of diagnosed diabetes in Native Americans seeking care in I/T/U facilities. Rates are calculated using the IHS automated record system (i.e., PCC/RPMS data), and are reported by geographic Area, gender, and age groups for adults. Three-year rates will be calculated to reduce variability. Three-year running rates (i.e., add the most recent year of data and drop the oldest year of data) will be used in trend analysis. Longitudinal studies of diabetes conducted in Pima Indians since 1965 have provided extensive information on the prevalence and incidence of diabetes in this tribal community. While there are several other tribal-specific diabetes epidemiological studies, none are to the depth of the Pima studies and they cover fewer than 10% of all tribes. Furthermore, there are no published studies on the growing problem of type II diabetes in American Indian youth, though there is extensive recognition by I/T/U providers that the age of diabetes onset is declining to younger adults and children.

Local/tribal facilities can assess diabetes prevalence by using PCC registries and /or diabetes case registries, deriving baseline measures for their tribal communities. The IHS Diabetes Program and the IHS Chronic Disease Epidemiology Program can assist I/T/U facilities to enhance their PCC registries and/or other diabetes registries, as well as establish and organize systematic screening and data entry in order to better ascertain diabetes prevalence. Emphasis will be placed upon the specific age groups identified for this measure.

Diabetes prevalence information will be collected, transformed into similar formats, and transferred to the CDC Division of Diabetes epidemiologist (interagency agreement between CDC and IHS) for analysis and adjusting. Reports will be created and disseminated to I/T/U's, other DHHS agencies, universities, and private foundations for use in identifying prevention strategies and resources.

Data Source: RPMS/PCC reports, Diabetes Registries

Baseline: These indicators commit to establishing and maintaining diabetes prevalence baselines using the IHS PCC and local diabetes registries that are used now in all areas. These

rates will serve as the baseline for tribal-specific prevalence studies in selected tribes and will be determined annually.

Type of Indicator: Process

Linkages: This indicator supports the President's initiative for diabetes, the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 5.1 *Improve Public Health Systems' Capacity to Monitor the Health Status and Identify Threats to the Health of the Nation's Population*. It is supported by IHS/CDC agreements, and supports several HP 2010 objectives in Focus Area 5: Diabetes.

Program Performance FY 1999: The FY 1999 performance measure was to establish the initial Area age-specific prevalence rates for diabetes and has been accomplished. Area age-specific diabetes prevalence rates have been prepared for the AI/AN population based on patients diagnosed with and treated for diabetes and having at least one outpatient visit during FY 1997. Rates are available by IHS Area and sex for 4 age groups (0-19, 20-44, 45-64, and 65+). Among the IHS adult population (age 20 and over) 9.6 % have diagnosed diabetes. Alaska Area has the lowest rate (2.9%); Nashville and Tucson Areas have the highest rates (16.1 and 17.9%, respectively).

Indicator 2 : Reduce diabetic complications by demonstrating a continued trend in improved glycemic control in the proportion of I/T/U clients with diagnosed diabetes in FY 2001.

Rationale: Large clinical studies have demonstrated that glycemic control significantly reduces the incidence of complications related to diabetes. In addition, achieving better blood sugar control has been shown to significantly reduce the costs associated with caring for people with diabetes. Using Staged Diabetes Management treatment guidelines for diabetes clinical management has significantly improved glucose control in several Indian communities.

Approach: The IHS Diabetes Program conducts a yearly medical record review of a random sample of nearly 10,000 charts in I/T/U facilities in order to assess compliance with the IHS Standards of Care for Diabetes. These standards are a set of clinical parameters of care and patient management that have a recognized evidence-based correlation with improved diabetic patient outcomes. This record review is known as the Diabetes Audit and uses a strict protocol to assure statistical integrity and comparability of both process and outcome measures over time. Each year, facility-specific values are reported for each indicator, as well as values for each Area and IHS-wide. Trends over time for I/T/U facilities, service units, Areas and IHS-wide are also constructed for selected indicators. Three-year running rates (i.e., add the most recent year of data and drop the oldest year of data) will be used to reduce variability and provide trend analysis.

Glycemic control refers to how well the blood sugars are controlled in a person with diabetes. It is measured with a blood test called the Hemoglobin A1c that measures the average blood sugar for a 2-3 month period. The IHS Diabetes Audit process divides these levels of control into "Acceptable", "Fair" and "Poor" categories based on national diabetes care standards. These categories will be used in the GPRA process to determine improvements in glycemic control.

The benefits of aggressive interventions to lower blood sugar in diabetics have been well described in the literature and numerous practice guidelines and standards exist. Local efforts to improve these parameters through lifestyle intervention and appropriate medication use will be encouraged. Local feedback of pertinent audit data will be provided to each site through the IHS Diabetes Program.

Data Source: Diabetes registries, yearly IHS Diabetes Program Chart Audit

Baseline: The 1998 Diabetes Audit reveals that 35% of all IHS clients were in the "good control" category; 36% of all IHS clients were in the "fair control" category; 17% of all IHS clients were in the "poor control" category; 7% of all IHS clients were in the "very poor control" category; and values were missing for 5% of clients. The proportion of all I/T/U patients with diabetes in "good" glycemic control for FY 1997-99 will serve as the baseline value and will be available by August, 2000.

Type of Indicator: Impact

Linkages: This indicator supports the President's initiative for diabetes, the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It is supported by IHS/CDC agreements and addresses Year 2010 objective 5-6 (Diabetes: diabetes-related deaths).

Program Performance FY 1999: Data for this indicator will be reported by August 2000 following analyses of the FY 1999 Diabetes Audit.

Indicator 3: Reduce diabetic complications by demonstrating a continued trend in improved blood pressure control in the proportion of I/T/U clients with diagnosed diabetes and hypertension who have achieved blood pressure control standards in FY 2001.

Rationale: Large clinical studies have demonstrated that blood pressure control significantly reduces the incidence of complications related to diabetes. In addition, achieving better blood pressure control has been shown to significantly reduce the costs associated with caring for people with diabetes. Using Staged Diabetes Management treatment guidelines for diabetes clinical management has significantly improved blood pressure control in several Indian communities.

Approach: The IHS Diabetes Program conducts a yearly medical record review of a random sample of nearly 10,000 charts in I/T/U facilities in order to assess compliance with the IHS Standards of Care for Diabetes. These standards are a set of clinical parameters of care and patient management that have a recognized evidence-based correlation with improved diabetic patient outcomes. This record review is known as the Diabetes Audit and uses a strict protocol to assure statistical integrity and comparability of both process and outcome measures over time. Each year, facility-specific values are reported for each indicator, as well as values for each Area and IHS-wide. Trends over time for I/T/U facilities, service units, Areas and IHS-wide are also constructed for selected indicators. Three-year running rates (i.e., add the most recent year of

data and drop the oldest year of data) will be used to reduce variability and provide trend analysis.

Blood pressure control is usually defined in the non-diabetic person as a blood pressure level less than 140/90 mm Hg. However, because a person with diabetes is at greater risk for complications related to blood pressure, national standards recommend that the ideal goal of diabetic blood pressure control should be 130/85 mm Hg. For the GPRA process, "acceptable" control will be defined as 140/90 mm Hg and "ideal" control will be defined as 130/85 mm Hg. and both levels will be reported.

The benefits of aggressive interventions to lower blood pressure in diabetics have been well described in the literature and numerous practice guidelines and standards exist. Local efforts to improve these parameters through lifestyle intervention and appropriate medication use will be encouraged. Local feedback of pertinent audit data will be provided to each site through the IHS Diabetes Program.

Data Source: Diabetes registries, yearly IHS Diabetes Program Chart Audit

Baseline: The 1998 Diabetes Audit reveals that 34% of all IHS clients were in the "normal blood pressure" category; 27% of all IHS clients were in the "controlled blood pressure" category; 27% of all IHS clients were in the "uncontrolled blood pressure" category; 8% of all IHS clients were in the "severely uncontrolled blood pressure" category; and values were missing for 4% of clients. The proportion of all I/T/U patients with diabetes in the "controlled" category for blood pressure control for FY 1997-99 will serve as the baseline value and will be available by August, 2000.

Type of Indicator: Impact

Linkages: This supports the President's initiative for diabetes, the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It is supported by IHS/CDC agreements and addresses Year 2010 objectives 5-6 (Diabetes: diabetes-related deaths) and 5-7 (Diabetes: cardiovascular deaths).

Program Performance FY 1999: Data for this indicator will be reported by August 2000 following analyses of the FY 1999 Diabetes Audit.

Indicator 4 : Reduce diabetic complications by demonstrating a continued trend of improvement in assessing the proportion of I/T/U clients with diagnosed diabetes for dyslipidemia (i. e., cholesterol and triglyceride) in FY 2001.

Rationale: Large clinical studies have demonstrated that lowering of serum cholesterol significantly reduces the cardiovascular (CVD) morbidity and mortality associated with diabetes. In addition, achieving better control of lipid parameters has been shown to significantly reduce the CVD costs associated with caring for people with diabetes. Using Staged Diabetes Management treatment guidelines for lipid management has significantly improved lipid control in-patients with diabetes.

Approach: The IHS Diabetes Program conducts a yearly medical record review of a random sample of nearly 10,000 charts in I/T/U facilities in order to assess compliance with the IHS Standards of Care for Diabetes. These standards are a set of clinical parameters of care and patient management that have a recognized evidence-based correlation with improved diabetic patient outcomes. This record review is known as the Diabetes Audit and uses a strict protocol to assure statistical integrity and comparability of both process and outcome measures over time. Each year, facility-specific values are reported for each indicator, as well as values for each Area and IHS-wide. Trends over time for I/T/U facilities, service units, Areas and IHS-wide are also constructed for selected indicators. Three-year running rates (i.e., add the most recent year of data and drop the oldest year of data) will be used to reduce variability and provide trend analysis.

The benefits of aggressive interventions to lower cholesterol levels in diabetics have been well described in the literature and numerous practice guidelines and standards exist. Local efforts to improve these parameters through lifestyle intervention and appropriate medication use will be encouraged. Local feedback of pertinent audit data will be provided to each site through the IHS Diabetes Program.

Data Source: Diabetes registries, yearly IHS Diabetes Program Chart Audit

Baseline: The 1998 Diabetes Audit reveals that 79% of all IHS clients had serum cholesterol values in their chart, 74% had serum triglyceride levels, and 29% had LDL cholesterol values recorded. The proportion of all I/T/U patients with diabetes who have had a cholesterol assessment done in FY 1997-99 will serve as the baseline values and will be available by August, 2000.

Type of Indicator: Impact

Linkages: This indicator supports the Secretary's initiative for diabetes, the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It is supported by IHS/CDC agreements and addresses Year 2010 objectives 5-6 (Diabetes: diabetes-related deaths) and 5-7 (Diabetes: cardiovascular deaths).

Program Performance FY 1999: Data for this indicator will be reported by August 2000 following analyses of the FY 1999 Diabetes Audit.

Indicator 5: Reduce diabetic complications by demonstrating a continued trend of improvement in the proportion of I/T/U clients with diagnosed diabetes who have been assessed for nephropathy in FY 2001.

Rationale: End stage renal disease (ESRD), or diabetic kidney disease, is a significant and growing problem in Indian communities. Large clinical studies have demonstrated that certain measurements can identify those patients at high risk for ESRD and that interventions aimed at reducing risk (blood pressure control, and other "state of the science" medications) may delay the onset of ESRD. Using the Kidney Health Profile of the diabetes audit and the Staged Diabetes

Management treatment guidelines for diabetes clinical management may significantly improve the approach to kidney health in Indian communities.

Approach: The IHS Diabetes Program conducts a yearly medical record review of a random sample of nearly 10,000 charts in I/T/U facilities in order to assess compliance with the IHS Standards of Care for Diabetes. These standards are a set of clinical parameters of care and patient management that have a recognized evidence-based correlation with improved diabetic patient outcomes. This record review is known as the Diabetes Audit and uses a strict protocol to assure statistical integrity and comparability of both process and outcome measures over time. Each year, facility-specific values are reported for each indicator, as well as values for each Area and IHS-wide. A special sub-report of the audit, called the Kidney Health Profile, is generated which assesses screening and treatment for kidney health in a community. Three-year running rates (i.e., add the most recent year of data and drop the oldest year of data) will be used to reduce variability and provide trend analysis.

The benefits of aggressive interventions to lower blood pressure in diabetics have been well described in the literature and numerous practice guidelines and standards exist. Local efforts to improve these parameters through lifestyle intervention and appropriate medication use will be encouraged. Local feedback of pertinent audit data will be provided to each site through the IHS Diabetes Program.

Data Source: Diabetes registries, yearly IHS Diabetes Program Chart Audit

Baseline: The 1998 Diabetes Audit reveals that 89% of all IHS clients had a serum creatinine on the chart and 81% had a urinalysis on the chart. Of these urinalyses, 29% showed positive proteinuria (i.e., protein in urine). Of those with no proteinuria, 33% had a test for microalbuminuria recorded in the chart. Because microalbuminuria is the most sensitive assessment for early diagnosis of diabetes, it will serve as the target measure. The proportion of all I/T/U patients with diagnosed diabetes screened for "kidney health" based on screening for microalbuminuria in FY 1997-99 will serve as the baseline and available by August, 2000.

Type of Indicator: Impact

Linkages: This indicators supports the Secretary's initiative for diabetes, the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It is supported by IHS/CDC agreements and addresses Year 2010 objective 5-11 (Diabetes: proteinuria).

Program Performance FY 1999: Data for this indicator will be reported by August 2000 following analyses of the FY 1999 Diabetes Audit.

Indicator 6: Reduce cervical cancer mortality and morbidity by increasing the proportion of women in FY 2001 who have had a Pap screen in the previous year by 3% over the FY 2000 level.

Rationale: This indicator is selected because cervical cancer occurs at higher rates among AI/AN women than in the general U. S. population. The death rate for AI/AN women is 4.1 per

100,000 compared with 2.5 per 100,000 for the U.S. All Races rate. Furthermore, this cancer is the cause of significant premature mortality, and is almost entirely preventable by thorough Pap screening and early treatment of pre-cancerous conditions. The long-range goal is to reduce both cervical cancer incidence and death rates to achieve parity with the U. S. all-races rate. This may be attainable within 10 years. This indicator supports a nationally recognized standard of care.

Approach: The IHS Office of Public Health is responsible for overall coordination of efforts to achieve these indicators. All Papanicolaou screening tests (cervical cytology or Pap smear) for cancer of the uterine cervix, performed during the previous year will serve as the numerator for this calculation. The denominator for this assessment will be all AI/AN women over age 18 who reside in counties included in the IHS Service Area, from the U. S. census. In addition, public education, training providers to perform colposcopy, added funding for screening and treatment, and aggressive follow-up of abnormal Paps will all be part of the strategy.

Data Source: The total number of Pap screens performed will be a composite of IHS Laboratory reports and PCC electronic records.

Baseline: Based for FY 1999 to be available by 4-1-00.

Type of Indicator: Impact

Linkages: This indicator supports the President's Initiative on Cancer Screening and Management, the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of*

Primary Health Services, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, 4.1 *Promote the Appropriate Use of Effective Health Care*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It is supported by IHS/CDC agreements (National Breast and Cervical Cancer Early Detection Program). This indicator also, directly supports the HP 2010 objective 3-4 (Cancer: cervical cancer deaths).

Program Performance FY 1999: The FY 1999 performance measure was to identify the incidence of cancer of the uterine cervix for AI/AN women. This indicator was partially accomplished. After a numerous analyses, the only reliable sources of data for this measure were determined to be: New Mexico Tumor Registry (a SEER site); Arizona Central Cancer Registry; Alaska Native Tumor Registry. These three registries include approximately 40% of the IHS user population and the rates vary between 8 and 10 cases per 100,000 women per year. The U.S. White rate during this same time was 8.5. Other state cancer registries were considered to be inaccurate because of high rates of racial misclassification, and because they often did not include Federal facilities (such as IHS and VA) in their database. Since complete accurate assessment of this measure is not currently available for the entire AI/AN population, the indicator was changed to address Pap screening for FY 2000 and FY 2001.

Indicator 7: Reduce breast cancer mortality and morbidity by increasing the proportion of the AI/AN female population over 40years of age during FY 2001 who have had screening mammography in the previous year by 3% over the FY 2000 levels.

Rationale: Breast cancer has long been considered to be rare among AI/AN women. Incidence and mortality rates have been documented in some AI/AN populations to be 1/3 to 1/2 of the White rates. This picture seems to be changing, however, with breast cancer incidence in the northern plains and Alaska now approaching the rates of the White population. Screening mammography was seldom performed by IHS before 1991, when the CDC National Breast and Cervical Cancer Early Detection Program was initiated. The CDC funded programs have been successful in reaching AI/AN women in many states, and not so successful in others.

Mammography is a nationally recognized standard of care based on its association with both reduced mortality and morbidity because breast cancer is identified at earlier stages. Early identification allows for early clinical intervention and secondary prevention of morbidity and mortality. For this indicator, the numerator will be the number of AI/AN women age 40 and older, registered for care with IHS, who have had a mammogram during the previous year and the denominator is all AI/AN women age 40 and older, who are registered for care with IHS (user population).

Approach: Local I/T/U service sites are responsible for delivering the screening. Regional coordination and assistance is the responsibility of the IHS Area offices. The IHS Office of Public Health performs the overall coordination of this effort. Linkages with NIH, CDC, and the American College of OB/GYN are critical to success.

The strategic approach includes outreach to improve patient access and the availability of specialized staff and equipment to perform the screening. The staff required are public health nurses, Community Health Representatives, and health educators to improve outreach, and specialized clinical providers (nursing, physician, and imaging staff) to provide the actual clinical breast exams and mammograms. The availability of screening must also be associated with the capability to provide diagnostic studies such as ultrasound, biopsy, and fine needle aspiration, as well as treatment such as surgery and chemotherapy.

The successful reduction of premature deaths and morbidity among AI/AN women will depend on full implementation of effective screening and follow-up clinical services. This indicator is linked to success in meeting Strategic Objectives one, two, and four of the Agency's component of the DHHS Strategic Plan.

Data Source: Three data sources will be combined for the total number of mammograms. First, the IHS Medical Imaging Program collects data on mammograms performed by IHS. These data will be supplemented with data from the CDC Breast and Cervical Cancer Early Detection Program, which serves AI/AN women in all states and 15 directly funded Tribes. The last source of data will be mammograms paid for by IHS but performed at non-IHS facilities, are captured by the IHS Fiscal Intermediary. Collectively these sources effectively serve as a reliable estimate of mammogram coverage for AI/AN women.

Baseline: Estimates from FY 1999 ranged from 27%-73% and are of limited usefulness. Using the methodology described above, a baseline for FY 1999 will be established by April 2000. This approach utilized for FY 1999, as described in the *Program Performance FY 1999* section below, has not proven useful.

Type of Indicator: Impact

Linkages: This indicator supports the President's initiative on Cancer Screening and Management, the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, 4.1 *Promote the Appropriate Use of Effective Health Care*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It is supported by IHS/CDC agreements (National Breast and Cervical Cancer Early Detection Program). This indicator directly supports HP 2010 objective 3-3 (Cancer: breast cancer deaths).

Program Performance FY 1999: The FY 1999 performance measure was to determine the proportion of AI/AN female population 50-69 years of age who had received annual mammography. Despite considerable effort, the data approaches used did not adequately meet this performance measure. Thus an alternative approach as describe above will be used and available by April of 2000.

For the initial approach to this indicator, data were collected from two sources: the CDC Behavioral Risk Factor Surveillance System (BRFSS), and the Indian Health Service annual Assessment of Diabetes Care. Based on the 1997 BRFSS, 73% of AI/AN women over age 50 responded that they had a mammogram within the past two years. The latest IHS Diabetes Audit to collect mammography data (1997) identified that 54% of diabetic women over age 40 had a mammogram documented in the medical record at any time in the past. By IHS Area, this ranged from 36% to 80%. For the same year, 27% of diabetic women over age 40 were in compliance with American Cancer Society recommendations (mammogram in past two years for age 40-49, in past year age 50 and up). By IHS Area, this ranged from 4% to 56%.

The BRFSS only reaches women with telephones, and so misses at least 20% of the AI/AN population. Probably those women without phones have lower socioeconomic status and are less likely to seek preventive services, so the BRFSS figure of 73% is almost undoubtedly a high estimate of mammography coverage. Another problem with BRFS is that relatively few AI/AN women are sampled, so this estimate is based on small numbers and may not be reliable.

The IHS Diabetes Audit is designed to be a scientifically valid sample of people with diabetes in IHS. In one recent study, diabetic women were found to have pap screening rates that were identical to women without diabetes, so we feel that it is reasonable to apply this survey for this purpose. The Diabetes Audit methodology requires documentation on the chart of the mammogram, so will probably not include mammograms that were performed at health fairs and other non-IHS sources that were not paid for by IHS. Therefore this rate of 27% should be considered an underestimate.

Probably the true figure for mammography coverage in IHS lies closer to 27% than 73%. Because the considerable expense necessary to resolve the problems with obtaining adequate data for this measure, the IHS has changed the assessment approach for this indicator for future years as described above. The age range has been also been changed to comply with the latest CDC recommendations.

Indicator 8: Improve child and family health by increasing the proportion of AI/AN children served by IHS receiving a minimum of four well child visits by 27 months of age during FY 2001 by 3% over the FY 2000 level.

Rationale: Well child visits have been associated with improved post-neonatal mortality and opportunities to improve family health and safety in the longer term and is a recognized national standard of care. Of particular importance are the anticipatory educational interventions given to parents concerning diet and nutrition, injury prevention, and prevention of family violence. The current minimum standard for Well Child Visits is six for first born children and five after first born. Accepting four visits as an acceptable minimum is based on the high percentage of children who receive Well Child services in conjunction with urgent care visits and thus are not coded as Well Child Visits.

Approach: The responsible parties are the local I/T/U service sites. The IHS Area offices can provide assistance in development and coordination of media campaigns and analysis of information and they are responsible for regional coordination of this effort. The IHS Office of Public Health is responsible for overall coordination of the effort. Linkages with the USDA-WIC program and the DHHS Head Start program are also critical.

The strategies for success are rooted in effective outreach and management of clinic scheduling for service provision. The outreach activity is dependent upon parent education to assure their awareness of the importance of routine and periodic assessment of well children. Secondly, the effective identification of children in the targeted age groups is important. Public health nursing, Community Health Representatives, Head Start programs, and parent groups have important roles in identifying children and families who are the target of this intervention.

Clinical care is dependent upon the availability of trained nursing and physician staff with the time to address this objective. Scheduling and follow up of these children and their families is critical. The cooperation of medical records staff and others in the clinical environment is essential. Achievement of effective well-child health care is critical to the prevention of childhood obesity, injuries, and family dysfunction. This objective is also consistent with the Secretary's Initiative on Improving the Health of Children.

Data Source: RPMS/PCC

Baseline: Determined by the FY 1999 Indicator and reported below

Type of Indicator: Process

Linkages: This indicator supports the Secretary's Children's Health Initiative, the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, and 3.6 *Improve the Health Status of American Indians and Alaska Natives* and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services* and broadly addresses the HP 2010 objectives addressing Focus Area 16: Maternal, Infant, and Child Health.

Program Performance FY 1999: The FY 1999 performance measure was to determine the proportion of the AI/AN children served by the IHS receiving a minimum of four well-child visits by 27 months of age. An automated extraction routine has been developed and run on FY 1999 service data that identified all children 3-3.5 years and then looked back four years to identify specified visits. Based on this initial run, out of 9,873 children, 3,799 or 38.5% of the children met the criteria. These findings should be considered provisional pending approval of the extraction approach by the Areas and final data verification.

Indicator 9: To reduce drug and/or alcohol use relapse of youths discharged from Regional Treatment Centers (RTC) during FY 2001:

- a. follow-up will be equal to or greater than the FY 2000 level**
- b. increase by at least 5% over FY 2000, the youths who have documented 6 months of less alcohol and drug use than before treatment**

Rationale: Studies indicate that the longer individuals are engaged in treatment (including aftercare/continuing care) the better the prognosis (Hoffmann, DeHart, & Gogineni, 1998; Zywiak, Hoffmann, & Floyd, 1999). One RTC evaluation concluded, "aftercare is the biggest problem" with limited coordination among RTC, service units and local aftercare programs retarding the effective and efficient delivery of treatment services at the local level following RTC release. This indicator is focused on assuring adequate follow-up care including an assessment of short-term relapse. A follow-up consists of a structured case management activity whereby continuity of care, treatment modalities and treatment services are assessed. This assessment of integrated aftercare activities is designed so that an individual's changing needs will be met as that individual moves through the recovery process thereby decreasing relapse.

Approach: The Division of Clinical and Preventive Services, Office of Public Health will be responsible for coordinating data collection from the Adolescent Regional Treatment Centers who are the responsible parties. The Alcoholism and Substance Abuse Program has developed an ongoing evaluation instrument in consultation with the RTC. The evaluation process began implementation in FY 1998 and includes follow-up information that will be reported to program staff and compiled for tracking this indicator. In addition, those RTC utilizing the RPMS Chemical Dependency Management Information System (CDMIS) and the RPMS Mental Health/Social Service (MH/SS) packages, routinely collect follow up information which can be exported for national reporting purposes. Aftercare services (for those utilizing CDMIS) occurring at local sites will also provide additional data to support tracking of this indicator.

Findings from the Comprehensive Assessment & Treatment Outcome Research adolescent study indicate that youth engaged in aftercare/follow up activities had better sobriety rates than those who did not, but for optimal benefit, contact frequency of at least twice per week was required (Hoffmann, Mee-Lee, & Arrowood, 1993). Although one-year follow-up information was limited in the IHS RTC Evaluation completed in FY 1997, data did suggest that youth that completed treatment and were involved in continuing care and follow up services maintained higher sobriety rates.

Data Source: CDMIS (IHS Alcoholism and Substance Abuse component of RPMS) and RTC Evaluation System.

Baseline: RTC Evaluation completed in 1997 only 50% of youth admitted between January 1993 and May 1995 received any follow-up care. Actual baseline was determined by FY 1999 Indicator 9 and reported below. A baseline assessment for abstinence rates following discharge will be collected during FY 2000 for comparison in FY 2001.

Type of Indicator: Process/Impact

Linkages: This indicator supports the Secretary's initiative to Prevent Youth Substance Abuse, the DHHS Strategic Plan, Strategic Objectives 1.4 *Curb Alcohol Abuse*, 1.5 *Reduce the*

Illicit Use of Drugs, 3.2 Increase the Availability of Primary Health Services, 3.6 Improve the Health Status of American Indians and Alaska Natives, and 4.2 Reduce Disparities in the Receipt of Quality Health Care Services. This indicator also directly supports HP 2010 objective 26-10 (Substance Abuse: reduce youth use of illicit substances).

Program Performance FY 1999: The FY 1999 performance measure was to determine the rates and intensity of follow-up care for adolescent discharged from IHS supported RTCs. This was accomplished and is continuously being updated through the ongoing use of the evaluation instrument that has been implemented. Based on this approach, the overall follow-up rate within the critical first 30 days was 64.5% for the 815 youths discharged from the 12 RTC in FY 1999. This rate drops to 55.2% for those who receive follow-up at 30 days and at least a second follow-up by 6 months, and down to 40.9% for those who receive follow-up contacts at 30 days, at least a second follow-up by 6 months, and at least a third at 12 months after discharge.

Indicator 10: Reduce the incidence of Fetal Alcohol Syndrome by increasing the proportion of I/T/U prenatal clinics utilizing a recognized screening and case management protocol(s) for pregnant substance abusing women by 10% over the FY 2000 level.

Rationale: Surveillance conducted at 2 IHS Areas indicated Fetal Alcohol Syndrome (FAS) rates exceeds general population rates (2.3 and 2.7/1000 live births vs. 0.6/1000 live births approximately). The Institute of Medicine 1996 report on FAS includes case identification and appropriate intervention and treatment of a maternal alcohol abuse as a critical part of FAS prevention. Thus, the purpose of this indicator is to assure that providers consistently screen and make appropriate referrals for women at risk. The written protocol makes this more likely because these efforts become part of the local quality assurance process. However, successful implementation of such a process requires staff training as well as cooperation from tribes and local governing bodies and thus requires resources and time.

Approach: The I/T/Us will be responsible for reporting via survey to be conducted by the Division of Clinical and Prevention Services, Office of Public Health relative to the implementation of protocols. Resources for analysis may be required from other divisions within the Office of Public Health. The Prenatal Health Assessment (PHA) screening instrument was developed in the Aberdeen IHS Area with the Centers for Disease Control and Prevention. A curriculum for utilizing the instrument in prenatal clinics and developing case management systems has been piloted in that Area in FY 1998. In the Aberdeen Area, there are numerous clinics and hospitals that are currently using the protocols. In FY 1999 the protocols will be piloted in two new Areas. This screening instrument is one of several recognized protocols which are being encouraged for use in I/T/U programs to assure the routine prenatal substance abuse screening and case management tailored to the resources of each site. The PHA is currently being reviewed by the Medical Records and will be provided for use nationally by the IHS end of FY 1999. A baseline will be established via the survey in 1999 and repeated in 2000.

Data Source: Survey and possibly RPMS

Baseline: Determined by FY 1999 Performance Indicator and reported by March 2000

Type of Indicator: Process

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 1.4 *Curb Alcohol Abuse*, 1.5 *Reduce the Illicit Use of Drugs*, 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. This indicator also directly supports several HP 2010 objective 16-16 (Maternal, Infant, and Child Health: Fetal Alcohol Syndrome).

Program Performance FY 1999: The FY 1999 performance measure was to determine the percentage of prenatal clinics utilizing screening and case management protocol for pregnant substance abusing women. Area reports will be compiled by March 2000.

Indicator 11: Reduce dental decay rates by improving water fluoridation compliance in FY 2001 by 10 % over FY 2000 levels for Areas participating in IHS/CDC Fluoridation Surveillance Demonstration Project.

Rationale: Fluoridation is one of the most cost effective public health measures for reducing the prevalence of dental decay in all age groups. Costs range from a mean of 31 cents per person per year to \$2.12 per person in communities with less than 10,000 people. For many Indian communities, the cost may be up to \$5 per person per year since most of the water systems in Indian country serve less than 1,000 people. It has been estimated that for every dollar spent on fluoridation, there is a \$50 savings in dental treatment. Fluoridation of community drinking water is a major factor responsible for the decline in dental caries (tooth decay) during the second half of the 20th century. In a 1991 oral health survey conducted by the Indian Health Service, there was a 31% decline in caries rates in adolescent children in those communities with access to fluoridated water. However, despite the known benefits of fluoridation, the number of fluoridated water systems in Indian country has declined by 200% over the last five years. This decline in systems has had an adverse impact in the percent of the population that needs the benefits most and are now receiving the least benefits from this proven public health measure.

Approach: The IHS Dental Program, Office of Environmental Health and Engineering Branch, and the Centers for Disease Control and Prevention's Division of Oral Health will enter into a cooperative agreement to support a demonstration fluoridation project in the southwest region. A fluoridation specialist will provide training and technical assistance to those tribes who want to fluoridate their community water systems. The concept of having an individual available to travel onsite and trouble-shoot problems and solve them with the water operator present has tremendous potential for learning and support of these individuals working in very isolated areas. The circuit rider will also monitor the monthly results and report them to a central data source. This will allow a better process for surveillance. The circuit rider will also train the operators in repair and maintenance of the equipment and help identify resources for needed equipment replacement. The circuit rider concept will also help demonstrate a model for small systems that can be applied to other rural areas as a cost-effective method for assuring the benefits of optimally fluoridated water to less populated communities.

Data Source: IHS Fluoridation Surveillance System and database are maintained at HQW.

Baseline: In FY 1997, 28 percent (96/340) of the tribally managed fluoridated water systems were in compliance. FY 1997, 39 percent (40/103) of the systems in the Phoenix, Albuquerque, Navajo, Albuquerque and Tucson Areas (southwest region) were in compliance.

Type of Indicator: Impact

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, 4.1 *Promote the Appropriate Use of Effective Health Care*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It also addresses HP 2010 objective 21-9 (Oral Health: community water fluoridation).

Program Performance FY 1999: No FY 1999 indicator.

Indicator 12: Improve oral health status by assuring that at least 25% of the AI/AN population obtain access to dental services during FY 2001.

Rationale: Available evidence supports that people who utilize dental services annually have improved oral health status compared to those who do not. The growing AI/AN population has resulted in higher demands for dental care and this problem has been compounded by increasing difficulties in recruiting dentists. As a result, there has been almost a 10% reduction in the percent of the AI/AN population annually receiving dental services in recent years. Restoring access to both primary and secondary treatment and preventive services can lessen the disease progression. Improving access and thus increasing utilization of dental services can also result in less costly care, improved oral health status, and quality of life. The IHS will be conducting a program-wide oral health survey in FY 1999 and FY 2000 to determine current oral health status of the AI/AN population, in light of reductions in access to care.

Approach: Providing access to care is directly dependent upon the dental care resources in a community which include adequate numbers of dental providers and facilities, and their efficiency in providing services. The requested dental funding enhancements for FY 2001 will be used to increase access to dental services through a combination of strategies that include:

- increase the I/T/U dental workforce by increased effectiveness in the recruitment of staff to fill vacant and newly funded dental positions using advance communications technologies, greater use of alternative pay systems, and expanded loan repayment opportunities.
- increase retention and productivity of dental providers through the expansion/enhancement of support centers to provide training and technical assistance to enhance efficiency and effectiveness of preventive and clinical care, and restoration of short and long-term staff training opportunities.
- update and simplify the automated dental record keep system to enhance clinical efficiency and planning and evaluation capability.
- expand essential dental specialty services through contracts with the private sector.
- target specific populations, (i.e., school-age children, diabetics or other special target groups), utilizing third party payers, and identifying Medicaid-eligible families which would result in increased resources to hire additional staff.

For the numerator of this calculation, the dental program will count the number of patients who access I/T/U and contract systems through the dental exam and first visit procedure codes within the Dental component of the PMS patient data record as a valid proxy measure of annual dental care utilization. The denominator will be the IHS three-year user population.

Data Source: IHS Dental Data System component of the RPMS.

Baseline: FY 1998 = 24.5%

Type of Indicator: Process

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives* and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*., This indicator also relates to the HP 2010 objectives 13.12 (Oral Health: referral and follow-up: children) and 21-10 (Oral Health: use of oral health care system).

Program Performance FY 1999: The FY 1999 indicator committed to achieving the target level of 21% of the AI/AN population receiving dental services. This performance measure has been achieved, but the goal was selected when preliminary data analyses for FY 1998 indicated that dental access had fallen to under 20%. Follow-up efforts to identify missing data through the verification of Area data submissions resulted in a revised access rate for FY 1998 of 24.5%. However, because vacancy rates for dental positions had increased dramatically in FY 1999 to the highest levels in history and approaching 20%, the target of 21 % was considered appropriate (see Section 1.4 *Recruitment and Retention of Health Care Providers* on page 15 in this document for a discussion of factors contributing to this problem).

Preliminary analyses of FY 1999 data show that access to dental care was 23%, and the number is likely to grow slightly when final missing data are secured.

Indicator 13: Reduce children's dental decay by assuring that the percentage of AI/AN children 6-8 and 14-15 years who have received protective dental sealants on permanent molar teeth in FY 2001 is increased by 3% over the FY 2000 level.

Rationale: Dental sealants, a recognized standard of dental care, are an effective measure for reducing dental decay rates in children and can be effectively applied by dental auxiliaries at relatively low cost. Sealants and fluorides can prevent almost all tooth decay and play a role similar to vaccinations. Because surveys of AI/AN children's oral health status have consistently identified significantly higher decay rates than the U. S. general population, sealants are essential to reducing the ravages and costs of treating dental decay. The IHS Dental Program was one of the few dental programs in the nation to have achieved the HP 1990 and 2000 dental sealant objectives. However, based on FY 1999 IHS Oral Health Survey, no significant progress has been achieved since the FY 1991 IHS Oral Health Survey and coverage actually declined for the younger age group, probably driven by an increasing difficulties in the recruitment and retention of dentists.

Approach: Local dental clinics are responsible for implementing/maintaining effective and efficient sealant programs that are either school-based or school-linked and targeted for children

ages 6-14 years (to coincide with the eruption of first and second permanent molar teeth). Use of a specialized procedure code, which was created specifically to measure use of sealants in school-age children, will enable local programs to track progress in meeting this objective. The Dental Data Software package in the RPMS environment can capture the number of children examined and the number of children who receive dental sealants on a quarterly and annual basis and thus document trends.

Data Source: IHS Dental Data System component of the RPMS.

Baseline: Based on FY 1999 IHS Oral Health Survey: 38.8% for 6-8 age group and 66.8% for 14-15 age group.

Type of Indicator: Impact

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. The indicator also addresses the HP 2010 objective 21-8 (Oral health: dental sealants).

Program Performance FY 1999: The FY 1999 performance measure was to assure that the percentage of children 6-8 and 14-15 years who have received protective dental sealants on permanent molar teeth was restored to at least 90% of the FY 1991 IHS Oral Health Survey level. This performance measure has been achieved for both age groups, although in terms of the original proposed target levels for the 6-8 age group. not based. The rates from the FY 1991 survey had originally been reported to be 57% for the 6-8 age group and 64% for the 14-15 age group. However, the statistician who analyzed both surveys identified one significant error in the 1991 analysis for the 6-8 age group and a lesser error in the 14-15 age group in the process of running comparison analyses. The data presented for the 6-8 age group from FY 1991 was actually only for the 7 and 8 year olds and had been printed in the monogram in error for 6-8 year olds. The finding for the older age group also changed slightly because the original calculation presented in the monograph had some missing data.

When the analyses for sealant assessment between the FY 1991 survey and the FY 1999 survey were standardized for valid comparisons, the rates for the FY 1991 survey were 40.1% for the 6-8 year olds and 65.5% for the children 14-15 years. Based on the FY 1999 IHS Oral Health Survey, of the 1479 children 6-8 years in the survey, 38.8% had sealants and of the 831 adolescents 14-15 years in the survey, 66.8% had sealants . Thus, both age groups exceeded the goal of 90% of the FY 1991 level with the 6-8 year olds at 97% and the 14-15 year age group at 102 %.

Indicator 14: Reduce the incidence and consequences of family violence, abuse, and neglect by assuring that in FY 2001 at least 80% of I/T/U medical facilities with Urgent Care or Emergency departments or services will have written policies and procedures for routinely identifying, treating and/or referring victims of family violence, abuse or neglect (i.e., child, spouse, and/or elderly).

Rationale: Family violence victims come to the health care system with a variety of physical injuries, illnesses or medical conditions directly related to abuse. The umbrella of family

violence includes child, spouse or elder abuse and/or neglect. Experts in the field of family violence have identified an important link between violence against women and the abuse of their children. Research indicates that children who witness violence in the family are affected in the same way as children who are physically and sexually abused (Goodman and Rosenberg, 1987). The propensity for family violence can extend to older members of the family (parents, grandparents, aunts, uncles) living in the home. The consequences of family violence can be seen in physical, psychological and cognitive results such as intentional and unintentional injuries, detachment, avoidance, depression, and suicidal ideation.

Thus, the purpose of this indicator is to assure that providers consistently screen for indications of violence, abuse or neglect and making appropriate referrals. The written protocol makes this more likely because these efforts become part of the local quality assurance process. However, successful implementation of such a process requires staff training as well as cooperation from tribes and local governing bodies and thus requires resources and time.

Approach: The Mental Health and Social Service program will work with IHS Area Offices to assure that staff are appropriately trained and local policies and procedures are established for these health concerns. Tribal and urban programs will also be encouraged to address these areas and IHS will respond to requests for assistance. Existing funds and staff will be utilized. Achievement of the indicator will assure local identification of family violence and those appropriate services for prevention and treatment of family violence, including the perpetrators, the individual victims, as well as the families and communities which suffer the consequences.

Data Source: Annual survey and/or progress review by IHS Area and Headquarters staff.

Baseline: Determined in FY 1998 to be at 47%. At that time 31 of 66 IHS Service Units had Policies and Procedures in place to address this indicator.

Type of Indicator: Process

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 2.4 *Improve the Safety and Security of Children and Youth*, 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. This indicator also addresses several HP 2010 objectives in Focus Area 15: Injury and Violence Prevention.

Program Performance FY 1999: The FY 1999 performance measure was to assure that at least 50% of I/T/U with urgent care or emergency departments would have written policies and procedures for routinely identifying, treating and/or referring victims of family violence, abuse or neglect. This performance measure was achieved as documented in a survey of 223 clinics and hospitals that showed that 64% had written policies and procedures for domestic violence. In addition, this survey demonstrated that clinics with policies and procedures in place were 2.36 times more likely to regularly screen patients for violence, abuse, and neglect.

Indicator 15: To improve mental health planning and evaluation, increase the number of I/T/U programs utilizing the Mental Health/Social Services (MH/SS) data reporting system during FY 2001 by 10% over the FY 2000 rate.

Rationale: The implementation of the MH/SS data reporting system will provide the vehicle for collection of baseline morbidity, mortality, services and workload data for IHS. Audits of the existing I/T/U data systems have documented both under-reporting and lack of specificity of mental health related conditions reported and services provided. Thus, the continued implementation of this management information system tool will provide a plethora of baseline formation that will enhance and complement national private and public outcomes monitoring efforts and allow consistent reporting, data aggregation for planning, managed care, and more effective billing and collection for services. This objective is also essential for monitoring many of the HP 2010 objectives addressing “Mental Health and Mental Disorders.” The proposed implementation level of an addition 10 percent of I/T/U sites is based on the resources available to provide the incremental hardware and software upgrades, as well as staff training.

Approach: Accomplishment of this indicator is contingent on several factors. The implementation of the RPMS data system should be mandatory and a priority within the IHS service system. Responsibility for the maintenance of the data system will be shared by the MH/SS program and Division of Information Resources, to assure clinical, technical and administrative viability.

Data Source: MH/SS component of RPMS.

Baseline: FY 1998 estimate of IHS program usage of MH/SS system is 40-45 % of the I/T/Us.

Type of Indicator: Process

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 2.4 *Improve the Safety and Security of Children and Youth*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 5.1 *Improve Public Health Systems' Capacity to Monitor the Health Status and Identify Threats to the Health of the Nation's Population*. This indicator also supports several HP 2010 objectives in Focus Area 18: Mental health and Mental Disorders.

Program Performance FY 1999: The FY 1999 performance measure was to assure that at least 50 percent of I/T/Us would have implemented the use of the MH/SS data reporting system. This measure has been achieved, with 115 of 227 I/T/U programs or 51% having implemented this system according to Area Information Systems Coordinators (ISCs). The breakdown by type of program is 85% for IHS run programs, 35% for tribal programs, and 60% for Indian urban programs. Expanding the use of this system continues to be a crucial component of the overall Behavioral Health efforts throughout the IHS, including tribal and urban programs.

Indicator 16: To improve planning and better define the needs and health conditions of urban Indian people, at least 30% of the Urban Indian health care programs will have implemented mutually compatible automated information systems which capture health status and patient care data by the end of FY 2001.

Rationale: Adequate health status and health services data are essential for the effective planning and management of any health care delivery system. Currently Urban Indian health programs capture data under the Urban Common Reporting Requirements (UCRR). These data are not currently compatible with other IHS health services data sets and only of limited use for the purpose of health systems management. Thus, the large urban AI/AN population has been

minimally represented in AI/AN data sets. The proposed implementation level of 30 percent is based on a schedule to provide the incremental hardware and software upgrades as well as urban program staff training.

Approach: A workgroup has been formed, comprised of Urban Programs health directors to review and revise the UCRR. The revised UCRR will capture an expanded set of data that are compatible with the IHS RPMS System, as well as provide local urban program managers better information about the health status and health services provided to their clients. Until a comprehensive needs assessment is completed it is difficult to estimate the resource requirements of this project; however, attempts will be made to, where feasible, avail the IHS RPMS system to urban programs so that systems are not duplicated. These indicators were developed to help monitor successful development of then updated urban data reporting system.

Data Source: Self-report of Urban health programs.

Baseline: No Urban Indian Health Programs with compatible information systems in FY 1998.

Type of Indicator: Process

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 5.1 *Improve Public Health Systems' Capacity to Monitor the Health Status and Identify Threats to the Health of the Nation's Population* and directly addresses the HP 2010 objective 23-4 (Public Health Infrastructure: data for select populations).

Program Performance FY 1999: The FY 1999 performance measure was to develop the specification and implementation plan for an automated mutually compatible information system which captures health status and patient care data for Indian Urban health care programs. This measure was accomplished by the writing of the Indian Urban Program Data Plan that was developed by an Indian Urban workgroup with the assistance from an information technology consultant. The plan includes full specifications for hardware and software to support a mutually compatible automated information system that captures health status and patient care data.

Indicator 17: To assure high quality health care, maintain 100% accreditation of all IHS hospitals and outpatient clinics during FY 2001.

Rationale: The accreditation of IHS hospitals and clinics represents perhaps the most objective and respected measure of health care quality. In addition, accreditation is essential for maximizing third-party collections, and contributes directly and indirectly to many other indicators presented in this plan.

Approach: The local I/T/U multidisciplinary team approach to accreditation and ongoing quality management has been the mainstay of success in this important activity. Additional support and guidance from Areas and Headquarters staff will continue to support this indicator. This will be one of the most demanding indicators to meet given the proposed funding levels available to support the backlog of health facilities maintenance, improvement, and renovation that is critical to accreditation. The accrediting body most frequently used is the Joint Commission on the Accreditation of Health Care Organizations (JCAHO).

Data Source: IHS compiled database generated from accreditation reports.

Baseline: 100% accreditation of IHS hospitals and outpatient clinics for FY 1997-98.

Type of Indicator: Process

Linkages: This indicator supports the Secretary's initiative to improve health care quality and the DHHS Strategic Plan, Goal 4, *Improve the Quality of Health Care and Human Services*, and Strategic Objective 3.6 *Improve the Health Status of American Indians and Alaska Natives* and broadly supports several HP 2010 objectives in Focus Area 1: Access to Quality Health Services.

Program Performance FY 1999: This indicator has been met as stated for IHS managed programs. A small isolated tribal program in the Phoenix Area, however, did not receive JCAHO accreditation as part of the Area-wide accreditation review in June 1999. The IHS accreditation level would be 98.7% for FY 1999 if tribal programs were included in the calculation. Furthermore, despite this one deficiency, the overall review of the Phoenix Area was very affirming for the IHS. At the closeout session the JCAHO review team leader stated that from his experience and the team's experience, the IHS program of the Phoenix Area was the best rural health care system in the United States that they had ever been involved with.

Indicator 18: By the end of FY 2001, improve IHS-wide consumer satisfaction by 5% over the FY 2000 baseline level.

Rationale: Assessing consumer satisfaction is fundamental to quality management and required for accreditation of hospitals and clinics. Furthermore, it is essential to meeting the President's Executive Order on "Setting Customer Service Standards" and the Secretary's initiative on improving the quality of health services.

Approach: In FY 1999 the IHS submitted a comprehensive culturally sensitive consumer satisfaction survey instrument for OMB clearance. In FY 2000 the instrument will be used to identify baseline scores for IHS hospitals and clinics. The strategy will be to survey patients (clients) in a sampling format to assess their views on various aspects of the services delivered, the manner in which the services are delivered, and provide the opportunity for offering suggestions for change or improvement. The information gathered will be analyzed and various local, Area-wide, or national policies or procedures will be considered for revision based on the findings. In FY 2001 the survey will be repeated to assess whether improvements have been realized.

The responsible parties for implementation are the local I/T/U service sites with assistance from the IHS Area office staff. The local staff will be part of the local quality assurance program and the aggregate staff will be part of the IHS epidemiology centers/program. Continued responsiveness to the patients and the AI/AN communities will be dependent (in part) on the achievement of this target.

Data Source: IHS Consumer Satisfaction Survey

Baseline: To be determined with initial FY 2000 survey

Type of Indicator: Process

Linkages: These indicators support the Secretary's initiative to improve health care quality and the DHHS Strategic Plan, Goal 4, *Improve the Quality of Health Care and Human Services*, and Strategic Objective 3.6 *Improve the Health Status of American Indians and Alaska Natives*.

Program Performance FY 1999: The FY 1999 indicator was to develop and submit a pre-tested culturally sensitive consumer satisfaction instrument to OMB for clearance by the end of FY 1999. The Survey instrument has been developed, revised through the use of focus groups, and additionally pre-tested. The agency administrative staff is currently in the end stages of refining the overall clearance package for final submission to the Office of Management and Budget for authorization for actual implementation the latter part of this FY2000.

In anticipation of a successful clearance and approval of the survey instrument, the agency has initiated program plans to enable the use of the survey instrument in each of the Indian Health Service clinics and facilities over a two year period. A national steering committee has been formed with five (5) members and two (2) staff. Field liaisons from each of the Areas in the Indian Health Services where IHS health facilities are located have been identified. A draft plan is being formulated for use in August 2000. Discussions regarding the cost have been ongoing and will be formalized when the draft plans are approved.

The instruments was developed and pre-tested but difficulties in preparing the OMB clearance package have delayed the submission process. However, the IHS will soon submit the package to OMB and may still be able to meet the FY 2000 measure of collecting a baseline assessment in late FY 2000, after OMB clearance has been obtained.

**FY 1999 Performance Summary Table 2:
Prevention Indicators**

Performance Indicator	FY Targets	Actual Performance	Reference
Indicator 19: Increase the total number of public health nursing services (primary and secondary treatment and preventive services) provided to individuals in all settings and the total number of home visits.	<u>Total Visits</u> FY 01: +7% increase over FY 00 FY 00: +7% over FY 97* FY 99: no indicator <u>Home Visits</u> FY 01: +7% increase over FY 00 FY 00: +7% over FY* FY 99: no indicator	FY 01: FY 00: FY 99: FY 97: total visits 339,283 baseline FY 01: FY 00: FY 99: FY 97: home visits 119,482 baseline	P: p. 55 B: p. IHS-76
Indicator 20: Increase the proportion of AI/AN children who have completed all recommended immunizations by the age two.	FY 01: +2% over FY 00 level FY 00: +2% over FY 99 level* FY 99: 91%	FY 01: FY 00: FY 99: 87% FY 98: 88% (baseline)	P: p. 56 B: p. IHS-76 p. IHS-37
Indicator 21: Increase overall pneumococcal and influenza vaccination levels among diabetics and adults aged 65 years and older.	FY 01: +2% over FY 00 level FY 00: 65%* FY 99: no indicator	FY 01: FY 00: FY 99: 3/00 FY 98: 63% baseline	P: p. 57 B: p. IHS-76 p. IHS-36
Indicator 22: Reduce the number of unintentional injuries for AI/AN people.	<u>Hospitalizations</u> FY 01: 70 per 10,000 FY 00: 71.5 per 10,000* <u>Deaths</u> FY 99: 93/100,000	FY 01: FY 00: FY 98: 72.5 /10,000 hosp. FY 96: 74.7/10,000 hosp. FY 99: 12/02 FY 94-96: 92.6/100,000 deaths	P: p. 58 B: p. IHS-52
Indicator 23: Increase percentage of I/T/Us that have implemented a suicide surveillance system to monitor the incidence and prevalence rates of suicidal acts (ideation, attempts, and completions) which assures those at risk receive services, and that appropriate population-based prevention interventions are implemented.	FY 01: 50% of I/T/Us implem. FY 00: no indicator FY 99: no indicator	FY 01: FY 00: FY 99: FY 98: estimated 25%	P: p. 60 B: p. IHS-48
Indicator 24: Establish model fitness programs at either IHS Area Offices or the I/T/U level.	FY 01: 5 sites established FY 00: no indicator FY 99: no indicator	FY 01: FY 00: FY 99: FY 98: one site established	P: p. 61 B: p. IHS-110

Performance Indicator	FY Targets	Actual Performance	Reference
Indicator 25: Maintain ongoing body mass index (BMI) assessments in AI/AN children 3-5 years old and/or 8-10 years old, for both intervention pilot sites and non-intervention comparison sites, as part of an overall assessment of the ongoing childhood obesity prevention project's effectiveness.	FY 01: implement program and monitor pilots and comparisons sites FY 00: develop five pilot sites* FY 99: develop approach and baselines	FY 01: FY 00: FY 99: approach and baseline accomplished	P: p. 62 B: p. IHS-34 p. IHS-37 p. IHS-130
Indicator 26: Develop at least five regional tobacco control centers to assist AI/AN health facilities and organizations with tobacco prevention and cessation activities.	FY 01: establish five tobacco control centers FY 00: establish baseline rates for tobacco usage FY 99: no indicator	FY 01: FY 00: baseline FY 99:	P: p. 64 B: p. IHS-35 p. IHS-136
Indicator 27: Implement local needs assessment to address HIV/AIDS infection in AI/AN communities.	FY 01: 50% implement needs assessment in 50% of I/T/Us FY 00: establish baseline rates FY 99: no indicator	FY 01: FY 00: baseline FY 99:	P: p. 65 B: p. IHS-68
Indicator 28: Develop environmental health surveillance system. And complete community environmental assessments in 90% AI/AN communities.	FY 01: 90% of communities assessed FY 00: develop surveillance protocol and plan* FY 99: no indicator	FY 01: FY 00: FY 99: no reliable baseline & no surveillance system in place	P: p. 66 B: p. IHS-51
Total Prevention Funding :	FY 01: \$123,243,000 FY 00: \$109,216,000 FY 99: \$102,712,000 FY 98: \$99,647,000 * indicates revised FY 2000 measure, see Summary of Changes Table on pages 87-70		P: page # in perform. plan B: page # in budget justif.

B. FY 2001 Prevention Indicators:

Indicator 19: **Improve the health status of American Indian and Alaska Native people by assuring that during FY 2001, the total number of public health nursing services (primary and secondary treatment and preventive services) provided to individuals in all settings and the total number of home visits are increased by 7% over the FY 2000 workload levels.**

Rationale: Public Health Nursing (PHN) is the integration of nursing practice and public health practice applied to the prevention of disease and the promotion and preservation of the health of Indian population. The nature of this practice is continuous and comprehensive, including all program areas and diagnostic groups. This includes primary and secondary treatment and preventive services, counseling, education, community development and referral follow-up. Many of the successes in Indian health such as decrease in infant mortality, high immunization rates, and increased prenatal care are attributed to the efforts of public health nursing.

The unique quality of PHN service is that care can be provided in any setting where the patient is accessible. This is especially effective for high-risk patients and families (e.g., substance abusing prenatal patients, infectious communicable disease cases, families with dysfunctional life styles, etc.). Settings include homes, schools, jails, bars, and other community locations in addition to the health clinic. The ability to meet the patient in their own environment allows the PHN to fully assess socioeconomic and quality of life variables that affect health status and facilitates rapport with patients who often distrust the formal health care system.

Approach: The population base for public health nursing services is the IHS census population residing within the official boundaries of the Area. The PHN/RRM standard indicates that PHN program addresses the needs of the community and therefore the appropriate target population is census population. However in some service units, the user population is greater than the reported census population, in these cases, the Indian user population is used as an estimate of the service population to reflect PHN service to both stable community and transient populations.

Providing access to PHN services is directly dependent upon the community based resources in a community that includes adequate numbers of PHN providers. Strategies for increasing care and its effectiveness includes targeting high-risk patients based on community epidemiological data and improving access for these targeted populations, (i.e., children, pregnant women, elders, etc.).

The percentage of population served by PHNs in any setting will be calculated by using total individuals served by the PHN in any location for the numerator and the greater of IHS Service Area or IHS user population for the denominator. The percentage of population served by PHNs in the home setting will be calculated by using total individuals served by the PHN in the home location for the numerator and the greater of IHS service area or IHS user population for the denominator.

It is anticipated that with the requested FY 2001 funding at least 25 additional public health nurse positions will be place in the field. This projected increase in staff reflects direct salary and benefit costs in addition to supporting services of secretaries, supplies, transportation, and consultation support centers. The projected increase in workload is at least 32,500 additional

patient services with at least 9,000 being in the home setting. PHN expert opinion and anecdotal historical performance standards reflect 1000 total visits per PHN as a minimally acceptable standard. A significant percent of these totals should be outside the health care facility.

Baseline: FY 1998 and 1999 workload will be reviewed and analyzed to define the baseline for the objective. Total national patient workload for FY 1997 is 339,283 and home visit workload is 119,482. Preliminary data analysis shows 26% of the Indian user population received PHN service in any setting and 9% of the Indian user population received PHN service in the home setting. This, however, was based on total visits rather than individuals served and, thus, would include duplicate patient counts. Because many tribal programs do not report PHN staffing or workload, this data too is considered estimated.

Specific data from one Area specific to individuals served in FY 98 shows 30% of user population receiving PHN service in all setting and 4% of user population receiving PHN service in the home setting. These are unduplicated counts. It also shows an average of 1510 total visits per PHN, 304 home visits per PHN, and 833 total individuals served per PHN.

Data Sources: IHS PCC, IHS service population and user population estimates, IHS Program Statistics Team.

Type of Indicator: Process/Impact

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It also broadly supports a multitude of HP 2010 objectives.

Program Performance FY 1999: No FY 1999 Indicator.

Indicator 20: Reduce the incidence of preventable diseases by increasing the proportion of AI/AN children who have completed all recommended immunizations for ages 0-27 months (as recommended by Advisory Committee on Immunization Practices) during FY 2001 by 2% over the FY 2000 rate.

Rationale: Immunizations are one of the most cost-effective public health measures available for improving health outcomes in children and are a recognized standard of care and immunization rates are a recognized standard of public health. Thus, vaccination coverage rates are a sensitive measure of the status of public health services and are essential in supporting the Secretary's Children's Initiative.

Approach: Percent of children vaccinated appropriately for age will be calculated for a representative sample of IHS service population children from each Area. Vaccines evaluated include polio (IPV), Diphtheria/Tetanus/Pertussis (DTAP), Measles/Mumps/Rubella (MMR), Haemophilus influenzae type b (HIB), Hepatitis B (HBV), and Hepatitis A (HAV). IHS completes these surveys on a quarterly basis. IHS will be primarily responsible for completing the surveys.

Data Source: IHS patient care records and public health nursing records.

Baseline: 87% based analyses of FY 1999 data.

Type of Indicator: Impact

Linkages: This indicator supports the President's initiative on childhood and adult immunizations and the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It also directly addresses the HP 2010 objectives in Focus Area 14: Immunizations and Infectious Diseases.

Program Performance FY 1999: The FY 1999 performance measure was to increase the proportion of AI/AN children who have completed all recommended immunizations by the age of two by 3% over the FY 1998 level which was 88%. When calculated as it was in FY 1998, the FY 1999 immunization rate for children is 89% or 2% under the goal. When calculated to include an Area that did not submit for last year's calculation the rate drops to 87%.

The reasons contributing to not meeting this performance measure include:

- high vacancy rates for health care providers, particularly nurses and public health nurses
- continued growth of new recommended vaccines make expanding coverage increasingly difficult
- significant turnover of Area immunization coordinators has resulted in disruption in attention to immunizations.

The turnover of Area immunization coordinators has at least temporarily been resolved and the IHS is working to address the recruitment and retention problems. For a more detailed discussion of this issue, see the section titled *Recruitment and Retention of Health Care Providers* on page 15 of this report.

Indicator 21: Reduce the incidence of preventable diseases, by increasing pneumococcal and influenza vaccination levels among adult diabetics and adults aged 65 years and older by 2% over the FY 2000 rates.

Rationale: Immunizations are one of the most cost-effective public health measures available for improving health outcomes. In addition, adult vaccination coverage rates are a sensitive measure of the status of clinical preventive services and are essential in supporting the Secretary's and IHS Director's elder health initiatives. This indicator also directly supports the HP 2010 "Immunizations and Infectious Disease" objectives.

Approach: Pneumococcal and influenza vaccination coverage rates will be calculated for a sample of IHS service population diabetic adults aged 65 years and older in each Area. These rates are to be collected and calculated by the Service Unit, Area, and Headquarters by diabetes personnel as part of the routine diabetes audit.

Data Source: IHS patient care records and public health nursing records.

Baseline: FY 1998 rate for adults receiving both influenza and pneumococcal vaccines was 63%.

Type of Indicator: Impact

Linkages: This indicator supports the President's initiative on childhood and adult immunizations and the DHHS Strategic Plan, Strategic Objectives 2.5 *Increasing Opportunities for Seniors to Have an Active and Health Aging Experience*, 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It also directly addresses the HP 2010 objectives in Focus Area 14: Immunizations and Infectious Diseases.

Program Performance FY 1999: No FY 1999 Indicator

Indicator 22: Reduce injury-related hospitalizations for AI/AN people to no more than 70 per 10,000 people for FY 2001.

Rationale: Injuries are a leading cause of hospitalization for AI/AN people relative to morbid events. Annually, forty six percent (46%) of the Years of Potential Life Lost (YPLL) for AI/AN people are the result of injuries. Furthermore, injuries are the number one cause of mortality for AN/AN people for ages 1-44 years and second for overall death rates. The IHS spends more than \$150,000,000 annually for the treatment of non-fatal injuries. The single largest expenditure of contract medical care funds are for the treatment of injuries. However, the systematic implementation of safety protocols through partnerships with tribes and outside agencies has demonstrated significant improvements in injury rates across AI/AN communities and will serve as models for further diffusion of these technologies.

Approach: The IHS has assigned a Principal Injury Prevention Consultant, in the Office of Public Health, at Headquarters who coordinates activities and resources with specially trained Injury Prevention Specialists at the Area, District, Service Unit and tribal levels. This program employs a community empowerment model based upon Dr. John Farquar's work at Stanford University (1985). Primary program emphasis is directed to building the capacity of tribes to recognize severe injury problems and employ evidence-based strategies to prevent or otherwise control injury outcomes. The Complete Injury Prevention Program model developed by IHS is the cornerstone of community-based intervention measures.

The IHS Five-Year Injury Prevention Strategic Plan identified the need for basic capacity building and investments in tribal and Federal infrastructures for the development of effective injury prevention programs. Since 1990, Congress has appropriated over \$3.5 million to injury prevention programs and competitively based intervention projects. In 1997 the Director, IHS, supported a national demonstration grant announcement for basic public health infrastructure projects within tribes. Approximately \$300,000 is awarded for the 13 tribal project sites. In addition to these projects, literally hundreds of Indian communities and Alaska Native villages are implementing proven injury prevention strategies associated with safe home and communities.

Most of the unintentional injury problem is related to motor vehicle crashes. Significant improvements can be made in these statistics with increases in use of occupant protection [safety belts and child safety seats], reducing pedestrian/motor vehicle collisions and reductions in alcohol-related injuries through multiple strategies including corrections in the physical

environments, changes in tribal policies and health promotion/education. These injury measures are identified in the Year 2000 Objectives and are relatively easy to measure.

In FY 2000 IHS will be implementing a \$1 million dollar cooperative agreement program with tribes to establish local injury prevention programs to address injuries. Other new initiatives are targeting childhood fire-related deaths through the *Sleep Safe* program in conjunction with Head Start schools, and continued work with our partners such as the Centers for Disease Control, the National Highway Traffic Safety Administration, and the US Fire Administration.

Data Source: In its original form from the FY 1999 performance plan, this indicator targeted injury mortality as the performance measure. However due to the time lag of 2-3 years in the release of official injury mortality data from the National Center for Health Statistics (NCHS), IHS has determined that injury-related hospitalization rates are a more appropriate measure for the rate of unintentional injuries and will use this measure for the FY 2000 and FY 2001 indicators.

By using this approach the lag time in obtaining data can be shortened to less than one year as compared the NCHS mortality data. In addition, these data include hospital discharges for IHS tribal and contract health care facilities and thus are considered inclusive. Finally, it is likely that the injury hospitalization rate may actually be more sensitive to the actual injury rates than mortality because improvements in emergency medical services could improve injury mortality without reducing the actual injury rate or morbidity.

Baseline: Estimated to be 72.5 per 10,000 in FY 1998 for AI/AN population on or near reservations.

Type of Indicator: Outcome

Linkages: These indicators support the DHHS Strategic Plan, Strategic Objectives 1.2 *Reduce the Number and Impact of Injuries*, and 3.6 *Improve the Health Status of American Indians and Alaska Natives*. It also directly addresses the HP 2010 objectives in Focus Area 15: Injury and Violence Prevention that relate to unintentional injury prevention.

Program Performance FY 1999: The FY 1999 measure for this indicator was to assure that the injury death rate was no greater than 93 per 100,000 deaths in the AI/AN population. While the data that is currently available is incomplete, it is highly likely that this measure has been met and possibly/probably exceeded. When the measure was initially set in FY 1998, the most recent rate available was 95 per 100,000 based on 1992-94 NCHS data. However, the FY 1994-96 data that became available last year showed that the rate had dropped to 92.6 per 100,000. Because of difficulties and delays in getting mortality data that we initially had hoped to overcome, we changed the indicator for FY 2001 and FY 2001, as described above, to focus on hospitalizations and the FY 1999 indicator was not revised.

Regardless of how injuries are measured, the community-based joint partnership approach that has been used has proven successful, as injuries (unintentional and intentional) have dropped from the leading cause of death for Indian people of all ages in the early part of the decade to the 2nd leading cause of death currently (heart disease is now the leading cause for all ages). And while seven IHS Areas still have rates that are above the FY 1999 mortality target, most of these areas are in the rural west, such as the Navajo and Aberdeen Areas, where travel distances are long and residents are at high risk for motor vehicle-related injury. However, these Area rates

have been trending downward over time, due to efforts in reducing impaired driving, tribes passing tougher drunk driving and occupant restraint laws, and stricter enforcement of these laws.

Indicator 23: Reduce suicide rates by assuring that by the end of FY 2001, at least 50% of the I/T/Us will have implemented a suicide surveillance system to monitor the incidence and prevalence rates of suicidal acts (ideation, attempts, and completions) which assures those at risk receive services, and that appropriate population-based prevention interventions are implemented.

Rationale: The suicide death rate for the AI/AN population has actually increased in the 1990s and is currently 72% greater than the national average. This problem has been particularly devastating for a number of AI/AN communities that have experienced dramatic increases in adolescent suicides in recent years and represents one of the greatest tragedies the IHS must address. The implementation of local suicide surveillance and prevention initiatives has been successful in reducing suicide acts in several Indian communities. The obvious goal of diffusing intervention approaches and learning from successful programs to other AI/AN settings is to reduce suicide acts in the AI/AN population as quickly as possible.

Approach: The I/T/Us will be responsible for reporting the implementation of protocols via survey to be conducted by the Division of Clinical and Preventive Services, Office of Public Health. Resources for analysis may be required from other divisions within the Office of Public Health. A suicide surveillance and prevention system was developed in the Albuquerque IHS Area (National Suicide Prevention Project with the Center for Disease Control and Prevention). A suicide surveillance instrument which identifies potential high risk individuals has been developed and is currently being used in clinics and case management systems have been piloted. Numerous clinics, hospitals and behavioral health programs are currently using suicide surveillance protocols and now simply need to be identified and counted. A suicide surveillance and prevention system is being encouraged for use in I/T/Us to assure the routine suicide screening and case management are tailored to the resources of each site. A baseline will be established via survey in 2000 and repeated in 2001.

Data Source: Local annual survey and database linked with RPMS as appropriate.

Baseline: To be determined with developed surveillance system

Type of Indicator: Impact

Linkages: These indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. This indicator also directly supports several HP 2010 objectives in Focus Area 18: Mental Health and mental Disorders which address the incidence of suicide.

Program Performance FY 1999: No FY 1999 Indicator

Indicator 24: Improve physical fitness and model fitness behavior by assuring that by the end of FY 2001, at least five model Take Charge Challenge fitness programs will be organized and functioning at either IHS Area Offices or the I/T/U level.

Rationale: The benefits of exercise and physical fitness in reducing the risk of obesity, diabetes, and cardiovascular disease have become increasingly clear over the past two decades. Within segments of the AI/AN population the prevalence of diabetes is the highest in the world while other segments with historically low diabetes rates are now experiencing dramatic increases. Furthermore, the diabetes death rate for AI/AN increased by almost 13 percent between the period of 1992-94 and 1994-96, and there is no evidence from any subgroup that the problem is lessening anywhere. The approaches currently available to prevent the onset of diabetes, and in some cases reverse its early stages, is the control of diet and exercise.

Thus the intent of this indicator is to develop a sufficient number of organizational sites modeling fitness behavior which can serve as successful models for others to follow along with the communities they serve. There is also evidence that the development of such programs at work-sites can serve to dissipate stress and improve the quality of work life which could ultimately contribute to achieving indicator 37 which addresses the quality of work life. The minimum number of 5 sites is based on an estimated threshold, or seed level, needed to assure some successful models to build organizational acceptance and diffusion to other work sites and communities.

Approach: In 1983 Mr. Bruce Leonard, an IHS health educator working at the Zuni Indian Reservation in New Mexico, developed a community-based exercise program that became well integrated into the Zuni community and continues today. In 1992 Mr. Leonard transferred to the CDC to work with states addressing a variety of issues including fitness and exercise. Working in this context, he revised, updated and expanded the fitness program for use in a variety of settings including work sites and communities. The approach has been piloted in 51 work sites in 21 states since 1995 (including the IHS Tuba City Service Unit) and was successfully implemented within CDC in 1996 as part of its 50th anniversary activities sanctioned by the then CDC Director, Dr. David Satcher. It is underpinned with the most recognized theoretical approaches to behavior change including stages of change, social learning theory, the diffusion of health innovations, and social marketing. The program is now called the "Take Charge Challenge" and is packaged such that it requires minimal resources and has data collection, evaluation, and cultural sensitivity built into its implementation process.

The IHS is working with CDC to formalize an agreement to utilize this successful approach in each IHS Area and then incrementally attempting to stimulate the diffusion of the intervention to a growing number of I/T/U sites.

Data Source: The Take Charge Challenge Data set

Baseline: One known program currently functioning in I/T/U settings.

Type of Indicator: Impact

Linkages: This indicator supports the President's diabetes initiative, the Secretary's chronic disease prevention initiative, the DHHS Strategic Plan, Strategic Objectives 1.3 *Improve the Diet and the Level of Physical Activity of Americans*, 3.6 *Improve the Health Status of American*

Indians and Alaska Natives, and 4.2 Reduce Disparities in the Receipt of Quality Health Care Services. This objective also directly supports several HP 2010 objectives addressing Focus Area 22: Physical Activity and Fitness, and will require significant collaboration between IHS, CDC, and tribes.

Program Performance FY 1999: No FY 1999 Indicator

Indicator 25: Reduce childhood obesity rates by maintaining ongoing body mass index (BMI) assessments in AI/AN children 3-5 years old and/or 8-10 years old, for both intervention pilot sites and non-intervention comparison sites, as part of an overall assessment of the ongoing childhood obesity prevention project's effectiveness.

Rationale: Obesity is prevalent among AI/AN people of all ages and is increasing significantly in a growing number of communities. Obesity is an important risk factor for cardiovascular disease and diabetes, which are perhaps the greatest single health problems for the AI/AN population. Unfortunately, success in reducing the prevalence of obesity and diabetes on a population basis has not been consistently documented. Evidence supports that children who are obese beyond infancy are at risk for elevated circulating serum insulin, which may be a precursor to the development of type II diabetes later in life.

Infant nutrition is emerging as another important factor in childhood obesity. Recently published studies of Pima Indians and also of Bavarian children show that breastfeeding for at least two months provides statistically significant protection from obesity in early childhood. It has also been demonstrated that obese older children are more likely to become obese adults. Fitness promotion and obesity prevention in childhood are expected to be more effective at preventing adult obesity and its complications, including type II diabetes, than weight reduction programs for adults.

It is the intent of this objective to pilot a series of at least five multidisciplinary/multidimensional community projects to address nutrition and fitness in early childhood. Ongoing periodic surveillance of school aged heights and weights will continue to monitor overweight prevalence in older children. Insights gained from the 6-year NIH-sponsored Pathways obesity prevention intervention in third, fourth, and fifth grade students, which began in FY 1997, provides larger-scale interventions for school children. The recently released Surgeon General's Report on Physical Fitness outlines additional intervention strategies for reducing obesity. This objective directly supports the HP 2010 objectives addressing "Nutrition" and "Physical Activity and Fitness."

Approach: The responsible parties are the local I/T/U, Head Start, and WIC service sites. The IHS Area and USDA Regional offices can provide assistance in development and coordination of media campaigns. The IHS Office of Public Health is responsible for overall coordination of the effort. The linkages with the USDA-WIC program, the USDA, the DHHS Head Start Program, CDC Nutrition and Physical Activity Division, and the National Diabetes Prevention Center in Gallup, NM are critical. This objective is linked in part to Indicator 8, assurance of well child visits.

The strategies for success require effective multidisciplinary outreach and management of clinic and community programs, coordination of WIC, well child care, and education programs such as Head Start and Early Head Start. This activity is dependent upon parent education to assure they are aware of the importance of routine and periodic assessment of well children. Secondly, the effective identification of children in the intervention age groups is important. Public health nutrition, public health nursing, Community Health Representatives, WIC, and Head Start programs, and parent groups are important components in identifying children and families who are to benefit from this intervention.

Coordination of maternal and child health clinical care, community activities, and community involvement are also critical to prevent childhood obesity. Interventions will be piloted and evaluated initially at selected, interested demonstration sites, and then successful strategies and ideas will be disseminated to all programs. Data will be collected through the IHS RPMS computerized health record system using the PCC BMI reports developed to measure prevalence of obesity in the clinic population. Coordination between the Pediatric Surveillance System managers at the CDC Nutrition and Physical Activity Division and the IHS Office of Public Health is critical for data access and analysis of the IHS Service Area data subset. This objective is also consistent with the Secretary's Initiative on Improving the Health of Children.

Data Source: CDC Pediatric Nutrition Surveillance System (PDNSS), and IHS RPMS system

Baseline: Determined by FY 1999 indicator and reported below.

Type of Indicator: Impact/Outcome

Linkages: This indicator commits to halting the accelerating rates of childhood obesity and thus supports the President's diabetes initiative, the Secretary's chronic disease prevention initiative, the DHHS Strategic Plan, Strategic Objectives 1.3 *Improve the Diet and the Level of Physical Activity of Americans*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. This objective also directly supports the HP 2010 objectives addressing Focus Area 22: Physical Activity and Fitness and Focus Area 19: Nutrition and Overweight and will require significant collaboration between IHS, CDC, WIC, and Head Start.

Program Performance FY 1999: The FY 1999 performance measure was to establish Area-specific prevalence rates for obesity in children ages 3-5 and 8-10 and develop a multidisciplinary and multidimensional intervention plan to address this problem. This measure has been accomplished. A data extraction process has been developed and successfully run that captures obesity rates from the RPMS patient record system. The use of this extraction routine will be expanded during FY 2000.

Findings from this initial run show expected high rates of childhood obesity in all age ranges determined by the criteria of being in the 95th percentile, or greater, of the Body Mass Index (BMI) based on the National Health and Nutrition Examination Survey II (NHANES II). For children in the 3-5 age group rate of obesity is about 20% and increases to about 25% for the children 8-10 years. While this method of assessing obesity may not provide research quality data, it is more than adequate for its intend of monitoring long-term trends.

The intervention plans for both age groups have come together as collaborative efforts with other HHS agencies. For the 3-5 year age group, the IHS has collaborated with Head Start in developing a Head Start- IHS Obesity Prevention Initiative entitled "Healthy Children, Healthy Families, Healthy Communities" that began in early 1999 with a "Future Search Conference" of stakeholders to begin planning the program with the broadest input. This program seeks to develop partnerships with AI/AN Head Start grantee programs, IHS and tribal health programs, and outside organizations. Interventions for this four-year initiative involve Head Start children, staff, families and AI/AN communities and address both nutrition and physical activity.

For the second age group, the IHS is assisting the Pathways intervention that is a large-scale trial for the primary prevention of obesity in 3rd-5th grade children. This project is funded by the National Institute of Health- National Heart, Lung, and Blood Institute and targets classroom curricula, physical activity, school food service, and family involvement.

Indicator 26: Reduce tobacco use by assuring that at least five regional tobacco control centers are available to assist AI/AN health facilities and organizations with tobacco prevention and cessation activities by the end of FY 2001.

Rationale: The use of tobacco represents a significant cause of preventable deaths in many AI/AN groups. Over 15 percent of all deaths in AI/ANs are related to cigarette smoking or use of other tobacco products and over \$370 million is spent annually for care of smoking-related illnesses. Experience has shown that tobacco control is best pursued at the local level. This is especially true when religious and cultural belief systems are involved, as is the case with tobacco and American Indians. To achieve meaningful progress in tobacco control, we need to empower and support AI/AN tribal organizations to work with their local communities. To this end we propose to establish regional tobacco control centers, located within existing tribal organizations, to encourage and provide technical support for local efforts.

The goal of five regional support centers to assist in tobacco control is based on current resources and program capability coupled with regional needs and anticipated growth and development. While more centers may eventually be needed, significant benefit can be anticipated with five.

Approach: Using funds already identified from CDC, issue a request for applications (RFA) for tribal organizations to develop regional support centers. Program direction will come from IHS Cancer Prevention and Control Program and CDC Office on Smoking and Health. The regional centers will become part of a national network for tobacco control among AI/AN.

Data Source: IHS Program records.

Baseline: Currently four AI/AN organizations are active in Tobacco control: Great Lakes Inter-Tribal Council, (Wisconsin); Northwest Portland Area Indian Health Board (Oregon); Alaska Native Health Board (Alaska); and the California Rural Indian Health Board (California). These centers all have a limited scope of activities and do not have resources to serve their entire region. Through this new RFA, we plan to increase the capacity of these centers and add new ones to serve multi-state and multi-tribe areas.

Type of Indicator: Process

Linkages: This indicator is new for FY 2001 and supports the Secretary's initiative to reduce tobacco use, and the DHHS Strategic Plan, Strategic Objectives 1.1 *Reduce Tobacco Use, Especially among Youth* 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 5.1 *Improve Public Health Systems' Capacity to Monitor the Health Status and Identify Threats to the Health of the Nation's Population*. It is supported by an IHS/CDC agreement, and supports several HP 2010 objectives in Focus Area 27: Tobacco Use.

Program Performance FY 1999: No FY 1999 Indicator.

Indicator 27: Reduce high risk HIV/AIDS behaviors by assuring that at least 50% of the I/T/Us will have implemented an HIV/AIDS Needs Assessment to monitor and assess risks by individuals and tribal communities and develop appropriate interventions.

Rationale: The HIV/AIDS rate of infection is 0.3% of the two million American Indian/Alaska Native (AI/AN) population. HIV/AIDS surveillance data collected in FY2000 will provide information on the infection rate on and off the reservation. A clear assessment of the current extent, patterns and trends of HIV infection among AI/ANs is necessary for public health planning, to ensure adequate prevention activities and access to health care. The IHS prevention effort is to target AI/AN youth. With average age at infection falling, and with half of the new infections occurring in individuals under the age of 25, interventions will target HIV prevention efforts at young people.

On a national survey of two groups, young gay men and young women infected through heterosexual sex, the infection rate accounted for roughly 75% of the adolescent epidemic. The epidemic in AI/AN is a microcosm, generally, of what is happening nationally. The incidence of HIV infection is growing in young people who are particularly vulnerable in society. The individual's ability to insist on safe sex or abstinence is likely to be affected by any social condition that damages self-esteem and a sense of control, limits resources, eliminates choices, or reduces access to information and tools of prevention. Young people at risk need far more than information about the biology and transmission routes of HIV. Prevention providers build on the foundations of traditional HIV prevention efforts-providing information and skills training to address the myriad of external forces challenging our AI/AN youth.

Approach: Utilization of the IHS RPMS data on HIV/AIDS within the Indian Health Service. CDC HIV/AIDS Semi-Annual Surveillance Report that gives information on American Indian/Alaska Natives. The standardized survey will be evaluated and monitored during the year. Information from this survey will identify deficiencies in HIV prevention and allow appropriate intervention by each of the I/T/U areas.

Data Source: Local annual survey and database linked with RPMS as appropriate; CDC HIV/AIDS Semi-Annual Surveillance Report.

Baseline: To be determined in FY 2000.

Type of Indicator: Process

Linkages: This supports the President's HIV/AIDS initiative and the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 5.1 *Improve Public Health Systems' Capacity to Monitor the Health Status and Identify Threats to the Health of the Nation's Population*. It is supported by IHS/CDC agreements, and supports several HP 2010 objectives in Focus Area 13: HIV.

Program Performance FY 1999: No FY 1999 Indicator.

Indicator 28: Reduce environmental threats to health by completing community environmental assessments of 90% of American Indian and Alaska Native communities in FY 2001 by the implementation of the environmental health surveillance system.

Rationale: Community environmental health status has traditionally been determined by completing environmental health surveys of individual facilities listed on the Facility Data System (FDS) inventory. However the overall environmental health status of a community is more than a simple sum of inter-related parts. An accurate determination of a community's environmental health status must be based on a comprehensive analysis of how those parts collectively affect the overall environmental health and quality of life of the residents of the community. Overall community environmental health status will be continuously assessed through the use of the environmental health surveillance system that will be developed during FY 2000. However to effectively measure improvement in the environmental health status of a community, baseline environmental health status must be determined by conducting initial comprehensive community environmental health assessments.

Approach: The Environmental Health Services program will work with the National Center for Environmental Health (NCEH), the National Association of City and County Health Officials (NACCHO), and Tribal partners to establish a surveillance protocol and implementation during FY 2000. This protocol will be employed in conducting the initial community assessment and for ongoing surveillance. At the regional level, this project will be coordinated with the IHS Area Environmental Health Officers in partnership with the tribes and local IHS environmental health services programs.

The collection, organization, and implementation of environmental health and epidemiological data may redesign the services and activities currently provided by and recommended by the Environmental Health Services program. We are not certain that the assumptions used to build the current system are still valid (FDS vs. risk-based decision making). Data analysis is necessary to establish baseline levels of community environmental health, evaluate the effectiveness of existing programs and to plan future programs to insure that resources and activities are best targeted to most effectively reduce environmentally related disease and injury at the local level.

Data Source: IHS Environmental Health Surveillance System developed in FY 2000.

Baseline: To be established by the end of FY 2001.

Type of Indicator: Process

Linkages: This indicator is an extension of FY 2000 Indicator 26. It supports the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 5.1 *Improve Public Health Systems Capacity to Monitor the Health Status and Identify Threats to the Health of the Nation's Population*. It also broadly supports many of the HP 2010 objectives in Focus Area 8: Environmental Health.

Program Performance FY 1999: No FY 1999 Indicator.

2.2.1 Capital Programming/Infrastructure Category: Program Description, Context and Summary of Performance

Program Description and Context

Capital Programming/Infrastructure indicators represent the physical infrastructure that contributes to a healthy environment by assuring safe water and sewage facilities, medical facilities where health services can be adequately provided, and the ability to maintain the medical facilities which are critical to our mission.

Sanitation Facilities Construction – supports the construction of water, sewage, and solid waste systems (see page IHF-14 in FY 2001 budget document).

Health Care Facilities Construction – supports the construction of new or replacement health care facilities (see page IHF-20 in FY 2001 budget document).

Maintenance and Improvement – supports ongoing health care facility maintenance, alteration, and repair (see page IHF-10 in FY 2001 budget document).

2.2.2 Capital Programming /Infrastructure: Performance Indicators

These indicators were selected and based on the following criteria:

- supports components of the Indian Health Facilities Appropriation and funding priorities of I/T/Us identified in the budget formulation process
- are supported by existing data systems that record the need for physical infrastructure or improvements to the existing infrastructure
- follows the formula-based prioritization of each project's relative need
- has demonstrable link to improved access to health services or healthier living environments

The data that support these indicators are recorded at the local level where projects are conceptualized based in strict protocols and formulas. These data are compiled at the Area and Headquarters level and reviewed for accuracy and they compare against similar projects. The validation of this information is essential to the facilities programs since it is used to distribute resources as well as measure performance. The link between funding levels and our ability to accomplish these indicators is relatively direct and supported by well-quantified and validated planning formulas.

These indicators support all of the Presidential, Departmental, and IHS initiatives by providing a foundation where health services can be effectively delivered and objectives reached. Without a healthy living environment, access to adequate medical facilities, and proper maintenance most of the objectives could not be met.

**FY 1999 Performance Summary Table 3:
Capital Programming/Infrastructure**

Performance Indicator	FY Targets	Actual Performance	Reference
Indicator 29: Address the net backlog of essential maintenance, improvement, and renovation (BEMAR) needs for health care facilities.	FY 01: address \$12 million of FY 2000 BEMAR FY 00: address \$12 million of FY 1999 BEMAR* FY 99: maintain backlog at \$243 million	FY 01: FY 00: FY 99: backlog maintained at \$243 based on FY 1998 formula FY 98: \$243 million baseline	P: p. 70 B: p. IHF-10
Indicator 30: Provide sanitation facilities to new or like-new homes and existing Indian homes.	FY 01: 3,800 New/L. New 10,930 Existing FY 00: 3,740 New/L. New 11,035 Existing* FY 99: 5,900 New/L. New 9,330 Existing Total 15,230	FY 01: FY 00: FY 99: 3,557 New/L. New 13,014 Existing Total 16,571	P: p. 71 B: p. IHF-14
Indicator 31: Improve access to health care by construction of the approved new health care facilities.	FY 01: complete scheduled phase of construction of appropriated facilities FY 00: complete scheduled phase of construction of appropriated facilities* FY 99: complete scheduled phase of construction of appropriated facilities	FY 01: FY 00: FY 99: projects completed on schedule	P: p. 72 B: p. IHF-20
Total Capital Programming/Infrastructure Funding:	FY 01: \$305,530,000 FY 00: \$277,303,000 FY 99: \$255,953,000 FY 98: \$221,009,000 * indicates revised FY 2000 measure, see Summary of Changes Table on pages 87-90		P: page # in perform. plan B: page # in budget justif.

FY 2001 Indicators

Indicator 29: To improve access to health care services, during FY 2001 the IHS will address \$12 million of the FY 2000 Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) for health care facilities.

Rationale: The provision of quality health services requires effective and efficient space, including reliable supporting building systems. This indicator represents a commitment to this activity that is also fundamental to maintaining hospital and clinic accreditation (see Indicator 17 on page 50).

Approach: This initiative is part of an IHS effort to more accurately determine the resources and processes required to sustain physical surroundings which enhance the delivery of health care services. This includes maintaining both IHS and tribal health facilities in good working order, eliminating environmental and safety hazards, and modifying space as needed to facilitate changing service delivery practices. To achieve this indicator, the IHS will complete an evaluation of the current listing of the BEMAR and initiate major maintenance and improvement projects that will result in the gross reduction to the 2000 BEMAR. It is important to note that the BEMAR continues to grow with additions in space, associated operating costs, aging of facilities, and improved data gathering.

The physical condition of IHS-operated, federally-owned and tribally owned health care facilities is evaluated continuously by local facility personnel and through annual general surveys conducted by local facility personnel and IHS Area Office engineers. In addition, comprehensive “Deep Look” surveys are conducted every five years by a team of specialists, which may include IHS and tribal engineers, architects, and operations experts, and occasionally technical specialists from private sector architectural/engineering firms.

A major facet of this initiative is an improvement of the data system in which identified facilities deficiencies are listed. The revised system will move input and querying of data to a lower level, Area Office and/or field sites, so the information may be used to support and improve decision making at those levels and the capturing of expenditures for capital improvements for buildings, as promulgated by the Federal Accounting Standards Advisory Board will be enhanced.

Data Source: Identified deficiencies recorded in the Facilities Engineering Data System.

Baseline: The 2000 backlog of identified deficiencies totaling \$446 million.

Type of Indicator: Process/Impact

Linkages: These indicators support the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives* and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services* and generally, many of the HP 2010 objectives.

Program Performance FY 1999: The FY 1999 performance measure was to maintain the net backlog of maintenance, improvement, and renovation needs for health care facilities at the FY 1997 level. For the two-year period, FY 1997 to FY 1999, approximately one third of the annually appropriated maintenance and improvement funding (\$25 million) were utilized for

projects to reduce the BEMAR. This enabled the IHS to meet the goal of maintaining the net BEMAR deficiency level, as defined in FY 1997, with the available funding.

However, the BEMAR was greater at the end of FY 1999, increasing from \$243 million in FY 1997 to \$446 million in FY 1999. This increase occurred in part because two new data tracking elements were added to the BEMAR during the period. Seismic deficiencies identified in compliance with Executive Order 12941, "Seismic Safety of Existing Federally Owned or Leased Buildings," were added during FY 1998 in the amount of \$149 million. Also, the facilities environmental database was added in FY 1999 in the amount of \$8 million. Several other factors contributed to the remaining increase in the BEMAR: 1) Increase in space - IHS has seen a continued trend in added space being provided for health care services. During the reporting period 522,000 square feet of space were added. The impact of the added space was not factored into the original GPRA goal. 2) Improved reporting - as the IHS improves its facilities data system, accessibility and usability of the system increases improved data gathering and updating; and 3) inflation factors were applied to portions of the cost data.

Indicator 30: Improve home environmental health by providing sanitation facilities projects to serve 3,800 new or like-new homes and 11,455 existing Indian homes.

Rationale: The IHS Sanitation Facilities Construction Program, an integral component of the IHS disease prevention activity, has carried out those authorities since 1960 using funds appropriated for Sanitation Facilities Construction to provide potable water and waste disposal facilities for American Indian and Alaska Native (AI/AN) people. As a result, the rates for infant mortality, gastroenteritis morbidity, and other environmentally related diseases have been dramatically reduced, as much as 80 percent since 1973. Compelling evidence supports that many of these health status improvements are attributable to IHS' provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations. Satisfactory environmental conditions (e.g., safe piped water and adequate sewage disposal) place fewer demands on IHS' primary health care delivery system. However, AI/AN homes are still seven times more likely to be without clean water than homes in the broader U.S. The current need for sanitation deficiencies as of the end of FY 1999 was \$1.753 billion. Of this total, \$770 million was considered to be technically and economically feasible projects.

Approach: The Indian Health Care Amendments (Title III, Section 302(g) 1 and 2 of P.L. 100-713) directed the IHS to identify the universe of Indian sanitation facilities deficiencies. From this process, a backlog of needed sanitation facilities was identified and regularly updated. It is feasible to provide sanitation facilities for between 95 and 98 percent of all existing Indian homes. Also included in the backlog are projects intended to upgrade existing water supply and waste disposal facilities and projects to improve sanitation facilities operation and maintenance capabilities in Indian country. Maximum health benefits will be realized by addressing needs identified and providing facilities for new/like-new homes when they are constructed.

Data Source: The Sanitation Facilities Deficiency System.

Baseline: Not Applicable

Type of Indicator: Impact

Linkages: These indicators support the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives* and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services* and several of the HP 2010 objectives in Focus Area 8: Environmental Health.

Program Performance FY 1999: The FY 1999 performance measure was to provide sanitation facilities to 5,900 new and like-new homes and 9,330 existing homes by the end of FY 1999. In FY 1999 the IHS provided sanitation facilities to 3,557 new and like-new homes and 13,014 existing homes for a total of 16,571. These exceeded the total goal of providing sanitation facilities for 15,230 homes.

The number of new and like-new homes served was less than the performance goal. The most significant reason was the large decrease in newly constructed HUD funded homes served in FY 1999. Only 461 HUD funded homes were served instead of the projected 1300 HUD homes. This decrease was due to the changes in the HUD Indian Housing programs authorized under the Native American Housing Assistance and Self-Determination Act of 1996 (NAHASDA). The NAHASDA increased the flexibility of tribally managed housing programs to independently meet tribal housing needs with programs beyond the traditional new HUD funded housing construction programs. As a result of NAHASDA, tribally managed housing programs are constructing new HUD funded homes, including associated sanitation facilities infrastructure, without requesting IHS assistance.

Sanitation facilities were provided for 13,014 existing homes in FY 1999, which exceeded the performance goal. This increase was the result of more projects to upgrade existing community sanitation facilities infrastructure. In spite of exceeding the goal for provision of sanitation facilities to existing homes, the backlog continues to grow. The current need for sanitation deficiencies as of the end of FY 1999 was \$1.753 billion. Of this amount, \$770 million was considered to be technically and economically feasible projects.

Indicator 31: Improve critically needed access to health care services by providing the following physical infrastructure:

Ft. Defiance, AZ Hospital	Continue construction of the replacement hospital and start design of part of the staff quarters.
Winnebago, NE Hospital	Continue construction of the replacement hospital.
Parker, AZ Health Center	Continue construction of the replacement health center.
Pawnee, OK Health Center	Start design of the replacement health center.
Small Ambulatory Construction Grants	Provide construction grants to tribes/tribal organizations.
Dental Units	Provide dental units based on priority needs.

The progress on these projects at the end of FY 2001 will be reported.

Rationale: Constructing replacement health care facilities increases access to personal medical services supported by the IHS. These medical services can be compared to medical services available to the general population (appointments to see primary care physicians, nurses, dentists, etc.). Efficient space for health care delivery allows for more appointments and for

patients to see more health care providers in one trip. People are also reluctant to use old run-down facilities but are more likely to seek needed health care when provided in modern facilities.

Likewise, modern facilities help recruit and retain health care providers that can result in improved access and continuity of health care. Once a replacement facility has been completed and fully staffed, IHS has experienced an average increase in patient visits of approximately 60% over the old facility (see page IHF-27 of budget for individual facility specifications). The designing of additional facilities is the first step in improving access for identified locations. Also, alternative methods of providing health care facilities are included (joint venture projects, small ambulatory grants, and non-IHS funds renovation projects).

Approach: The IHS developed the Health Facilities Construction Priority System (HFCPS) methodology in response to congressional directive to identify planning, design, construction, and renovation needs for the 10 top-priority inpatient care facilities and the 10 top-priority outpatient care facilities and to submit those needs through the President to the Congress. Under the three-phase HFCPS process, the IHS Headquarters solicits proposals for health facility construction from the Area Offices and ranks them according to their relative need for construction. Factors used to determine relative need are workload, age, isolation or alternatives to construction, and existing space data. The highest-ranking proposals are added to the Priority Lists.

When new projects are to be added to the Priority Lists, IHS Headquarters asks each IHS Area Office to submit proposals for Phase I consideration. The IHS uses the HFCPS methodology to review these proposals and to determine which will be considered during the more intensive Phase II review. A limited number of proposals that successfully complete Phase I are considered further during Phase II. The IHS examines these proposals in greater detail and applies the methodology to determine those proposals that will be considered during Phase III.

During Phase III, appropriate IHS Area Offices prepare a Program Justification Document (PJD) for each proposed project still being considered. IHS Headquarters reviews each PJD. If the PJD justifies construction, it is approved and the project is placed on the appropriate priority list below those already on the list. Proposed projects that have been approved and placed on a priority list remain on the list until they have been fully funded by congressional appropriations or other funding mechanism.

After projects are placed on the Priority Lists, IHS updates its 5-year planned construction budget. That budget is updated yearly and used as the basis for funding requests. The HFCPS is generally applied using existing IHS resources (staff and equipment); however, some Area Offices have procured assistance in developing the PJD and POR.

Data Source: Health Care Facilities Priority System and Health Care Facilities Planned Construction Budget (5-Year Plan).

Baseline: Not Applicable, the IHS Inpatient and Outpatient Facilities Priority List is used to determine needed construction priorities.

Type of Indicator: Process/Impact

Linkages: These indicators supports the DHHS Strategic Plan, Strategic Objectives 3.6

Improve the Health Status of American Indians and Alaska Natives and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services* and generally, many of the HP 2010 objectives in Focus Area 1: Access to Quality Health Services.

Program Performance FY 1999: The FY 1999 performance measure was to reach the completion phase of construction for the Hopi (Polacca), Arizona Health Center, and starting construction of the Ft. Defiance, Arizona Hospital and the Parker, Arizona Health Center by the end of FY 1999. This measure has been accomplished and can be summarized as follows:

New Hopi Health Center, Polacca, Arizona: The FY 1999 appropriation fully funded the project and allowed the tribe, under a P.L. 93-638 contract, to obligate funds for completion of the project. The construction is on schedule to be completed in the third quarter of FY 2000.

Replacement Hospital, Fort Defiance, Arizona: Using the FY 1999 appropriation, the previously completed design for the replacement hospital portion of the project was updated and construction was started in September 1999.

Replacement Health Center, Parker, Arizona: Using the funds appropriated in FY 1999, construction began in June 1999, pursuant to a P.L. 93-638 contract.

2.3.1 Partnerships, Consultation, Core Functions, and Advocacy Category: Program Description, Context and Summary Performance

Program Description and Context

The Partnerships, Consultation, Core Functions, and Advocacy aggregation encompasses the IHS' administrative and management functions, relationships with stakeholders and consumers, and strategies for collaboration in pursuit of the IHS mission. Data for these indicators come from recognized sources including budget reports and audits, a HHS survey, and a survey of the universe of stakeholders using recognized social survey methods. The two components of this aggregation are:

Partnerships, Consultation, Core Functions, and Advocacy Category Aggregation

Direct Operations - supports management and administrative functions for Area and Headquarters staff including policy development, budget formulation, health program support, and accountability requirements (see page IHS-110 in FY 2001 budget document).

Facilities and Environmental Health Support - provides administrative and management support for the construction, maintenance, and operation of health care facilities, staff housing, and sanitation facilities (see page IHF-41 in FY 2001 budget document).

2.3.2 Partnerships, Consultation, Core Functions, and Advocacy Category: Performance Indicators

The choice of indicators for this aggregation category are based on the following criteria:

- supports and encourages tribal sovereignty, the government to government relationship between tribes and the Federal government, and tribal self-determination
- supports and encourages collaboration with stakeholders, agencies, and organizations directed toward improving the health of AI/AN people
- supports and encourages sound management practices

Achieving these performance indicators, as well as the overall coordination of the GPRA and other Federal accountability requirements represent a significant challenge for the IHS and its reduce management and public health infrastructure. The reorganization of Headquarters and many Area offices has resulted in flatter organizational structures, less specialization in function, and greater use of self-directed teams in order to increase efficiency. However, it has become increasingly clear that coupled with improved data management capacity, two functions must adequately supported to assure overall program success and these are:

- assuring that continued and expanded opportunities for tribal consultation and participation in IHS endeavors is supported
- assuring effective recruitment of needed health discipline is achieved and that orientation, training, and support are available to enhance the retention these staff.

**FY 1999 Performance Summary Table 4:
Consultation, Partnerships, Core Functions, and Advocacy Indicators**

Performance Indicator	FY Targets	Actual Performance	Reference
Indicator 32: Improve the level of I/T/U satisfaction with the processes for consultation and participation provided by the IHS, as measured by a survey of I/T/Us.	FY 01: secure OMB clearance for instrument FY 00: revise policy and instrument * FY 99: establish policy and collect baseline	FY 01: FY 00: FY 99: policy established but baseline delayed	P: p. 77 B: p. IHS-110
Indicator 33: Improve the level of Contract Health Service (CHS) procurement of inpatient and outpatient hospital services for routinely used providers under contracts or rate quote agreements at the IHS-wide reporting level.	FY 01: 88% FY 00: no indicator FY 99: no indicator	FY 01: FY 00: FY 99: NA FY 97: 85.4% baseline	P: p. 78 B: P. IHS-62
Indicator 34: Maintain administrative infrastructure (Area and Headquarters) no higher than FY 1999 target level while maintaining full compliance with major Federal requirements (i.e., GPRA, GMRA, ITMRA, etc.).	FY 01: 1876 FTE or less FY 00: 1876 FTE or less* FY 99: at least 10% under FY 97 level or 1876 FTE	FY 01: FY 00: FY 99: -22% (1,619 FTE) FY 97: 2085 FTE baseline	P: p. 79 B: p. IHS-110
Indicator 35: Increase the number of interagency agreements and cooperative agreements with agencies and organizations that are directly linked to performance plan indicators.	FY 01: increase over FY 00 FY 00: increase over FY 99* FY 99: increase by 10% over FY97 or 73 agreements	FY 01: FY 00: FY 99: 86 total agreements FY 97: 66 agreements baseline	P: p. 80 B: P. IHS-110
Indicator 36: Continue implementation of Managerial Cost Accounting systems across IHS setting.	FY 01: secure IT capability FY 00: develop pilot sites* FY 99: begin implementation	FY 01: FY 00: FY 99: "cost centers" implemented in FY 1999	P: p. 81 B: P. IHS-110
Indicator 37: The IHS will improve its overall Human Resource Management (HRM) Index score as measured by the DHHS annual HRM survey.	FY 01: at least 95 points FY 00: at least 94 points* FY 99: no indicator	FY 01: FY 00: FY 99: 93 points FY 98: 93 points baseline	P: p. 82 B: P. IHS-110
Total Consultation, Partnerships, Core Functions, and Advocacy Funding:	FY 01: \$78,084,000 FY 00: \$72,884,000 FY 99: \$69,729,000 FY 98: \$67,038,000 * indicates revised FY 2000 measure, see Summary of Changes Table on pages 87-90		P: page # in perform. plan B: page # in budget justif.

FY 2001 Partnerships, Consultation, Core Functions, and Advocacy Indicators

Indicator 32: To improve the IHS consultation process with its I/T/U stakeholders, during FY 2001 the IHS will implement the revised consultation policy and secure OMB clearance for the instrument to assess I/T/U stakeholder satisfaction with the consultation process.

Rationale: It is fundamental to the intent of the NPR and the realization of the IHS Mission and Goal that I/T/Us increasingly become participating partners in the important processes which will guide the Agency into the next century. Given the number and diversity of I/T/Us, formal policies are essential to assure broad input, a rational and equitable approach to making timely decisions, and the highest possible buy-in across I/T/Us. Equally important is securing the data to assess how well the processes are actually working, and then improving them. In addition, this indicator serves as a proxy measure of the effectiveness of the IHS Tribal Management program. Finally, during the initial reorganization of the IHS in 1995-96, the IHS was encouraged by its stakeholders to assure opportunities for local I/T/Us to evaluate the agency's progress in enhancing the consultation process and supporting recommended changes.

Approach: It is critical that the IHS form a strong and effective partnership with its I/T/U constituents in addressing the health disparities. This partnership is essential to ensure that resources are effectively and efficiently utilized to maximize the positive impact health programs have on the target I/T/U populations. Partnerships already exist with such tribal entities as the National Indian Health Board (NIHB), Regional Indian Health Boards, the Tribal Self-Governance Advisory Committee (TSGAC) and the National Congress of American Indians (NCAI).

The starting point for this initiative was with the development and implementation of the IHS consultation policy and was to be followed by the development of a survey instrument to assess I/T/U satisfaction with the consultation process. This policy was actually developed ahead of schedule and was in effect at the start of FY 1999. In addition, a survey instrument was developed and tested in the spring of FY 1999. This survey instrument was to be used in FY 1999 to establish a baseline and was to be accomplished by several tribal and AI/AN organizations. However, concerns about the how the consultation process was being implemented refocused the attention of the I/T/U stakeholders on revising the policy to address specific consultation processes. As a result the collection of data was delayed pending the revision of the policy by a team that includes the I/T/U stakeholders.

The IHS has elected to honor our stakeholders' preferences and will support the revision of the consultation policy/process for FY 2000 and concurrently revise the survey instrument to reflect changes in the policy. For FY 2001 the IHS will implement the revised policy and submit the revised instrument to OMB for clearance.

Data Source: I/T/U survey instrument and protocol

Baseline: From baseline survey completed in FY 1999.

Type of Indicator: Process

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives* and 4.3 *Increase Consumer's Understanding of their Health Care Options*. It also underpins the IHS' commitment supporting the Self-Determination process and AI/AN community empowerment.

Program Performance FY 1999: The FY 1999 indicator committed to establishing the consultation policy, developing a satisfaction survey, and securing the baseline level of satisfaction. This performance measure has been partially completed. The policy was developed and implemented well ahead of schedule and the survey instrument was developed and tested in the spring of FY 1999. However, as described in the "Approach " section, data collection with a survey instrument has been delayed to coincide with the revised policy and the need for OMB clearance. The IHS has elected to prioritize stakeholder participation and preferences over a predetermined schedule.

Indicator 33: During the FY 2001 reporting period, the IHS will have improved the level of Contract Health Service (CHS) procurement of inpatient and outpatient hospital services for routinely used providers under contracts or rate quote agreements to at least 88% at the IHS-wide reporting level.

Rationale: It is important that IHS optimize its use of CHS resources. CHS regulations require the use of medical priorities to assure that persons with the most urgent need receive services and that alternate resources pay prior to IHS expending funds. Beyond these built-in requirements, IHS is making efforts to assure that we receive the best price available from our routine providers of care. To that end, we are seeking to ensure that contracts or rate quote agreements are in place that provide reduced rates to IHS and its patients with routinely used hospitals. While not every routinely used hospital will agree to some reduced rate schedule with IHS, many will, and it is to our advantage to continue to aggressively pursue cost-effective arrangements.

Approach: It is not feasible to pursue contracts or agreements with every hospital that provides services to IHS patients. Some hospitals are utilized on a one-time emergency basis when it is impossible for the patient to be moved to a contract facility, or when there is no contract facility in the vicinity. In other cases, the utilization of the facility is so infrequent that it is impractical to contract with that facility for a small number of patient visits per year. Therefore, IHS is only interested in obtaining contracts or rate quote agreements with frequently used providers.

Frequently used hospitals are defined as those facilities to which IHS paid more than \$50,000 for inpatient services per year and/or more than \$10,000 in outpatient services per year. Not all hospitals meet both criteria, and inpatient and outpatient service contracts and rate quotes will be tracked separately.

To calculate the percentage rate we divide the amount paid to frequently used hospital providers with contracts or rate quote agreements, by the amount paid to all frequently used hospital providers. The IHS fiscal intermediary (FI) , who makes IHS' CHS payments, will provide these amounts. The FI also maintains information on contract and rate quote agreements and applies the contract or agreement rate to the payment. Records are maintained by individual provider and composite data can be provided by the FI.

Data Source: The IHS Fiscal Intermediary – Blue Cross and Blue Shield of New Mexico. The IHS will use FY 1997 claims paid data as the baseline. For this year the calculated rate is 84.4 percent. The reason why the baseline of FY 1997 is chosen is that the data are 99 percent complete.

Type of Indicator: Process

Linkages: These indicators support the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives* the accountability requirements of a DHHS OPDIV, and support H P 2010 objectives in Focus Area 1: Access to Quality Health Services.

Program Performance FY 1999: No FY 1999 Indicator.

Indicator 34: During FY 2001, the IHS Headquarters and Areas will maintain full compliance with major Federal requirements (i.e., GPRA, GMRA, ITMRA, etc.), without expanding the administrative staff above the FY 1999 FTE target level.

Rationale: A major recommendation in the IHS reorganization plan was to downsize and streamline the IHS Headquarters and Area Offices and move from controlling and directing to providing consultation and support to I/T/Us. This recommendation supports the continued transition to local control, and the intent of the NPR, but represents a significant challenge because of the loss of economies of scale in the decentralization process. In the FY 1999 performance plan the IHS committed to reducing the number of FTE s in IHS Headquarters and Areas by 10 percent over the FY 1997 level.

For FY 2001 the IHS is committing to maintaining the reduced Area and Headquarters administrative FTE level at the target FY 1999 level (i.e., 10% below the FY 1997 level) and to focus resources at providing access to services. Further reductions in administrative positions will be considered with caution given the increasing accountability requirements for which the Agency must be responsive and the importance of field support.

Approach: To accomplish this indicator the IHS continues the process of reorganizing Headquarters to a flatter and simpler structure and integrating the use of multi-disciplinary teams to address important functions, including the GPRA. Many Areas are also reorganizing to more efficient structures. Likewise, the IHS is well along in its Y2K conversion plan addressing five mission-critical information systems and will meet the necessary requirements associated with this activity.

As described in Performance Indicator 35, we are attempting to expand the development of partnerships with outside organizations to bolster our capacity to serve the needs of AI/AN people. Doing more of what is important without expanding administrative overhead will require considerable training and improved technologies, as well as ceasing to expend resources on low value work.

The evaluation of our success in this attempt at achieving more will come from the surveys of I/T/Us described in Performance Indicator 32. Feedback will come from the Department, OMB,

and Congress relative to our level of compliance with the growing number of Federal requirements, particularly the GPRA, GMRA, ITMRA, and audits of the resources expended. In the long run, our success in this efforts will be reflected to a considerable degree in the level of realization of our component of the DHHS Strategic Plan and the IHS Mission and Goal.

Data Source: Audits of Area and Headquarters, I/T/U Survey, and feedback from HHS, OMB, and Congress.

Baseline: FY 1997 Area and Headquarters FTEs = 2085

Type of Indicator: Process

Linkages: These indicators support the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives* and the accountability requirements of a DHHS OPDIV.

Program Performance FY 1999: FY 1999 Indicator 25 committed to reducing Area and Headquarters staff by 10% below the FY 1997 level of 2085 FTEs (i.e., 1876 FTEs) and maintaining compliance with Federal requirements. This indicator has been achieved with FY 1999 total Area and Headquarters FTEs level of 1,619 or a 22 % decrease while meeting compliance standards. However, the large reduction in FTEs that has occurred with reorganization is greater than anticipated and has left "function holes" in the IHS infrastructure that are essential to replace to assure that the IHS can meet its accountability requirements. Thus, the IHS is committing to maintaining the target level (i.e., 1876FTEs) rather than the actual FY 1999 levels for this performance measure for FY 2000 and FY 2001 (see summary of changes to FY 2000 plan on pages 87-90 of appendix).

Indicator 35: To increase collaborative support for improved health status of AI/AN people, the IHS will have increased the number of interagency agreements and cooperative agreements with agencies and organizations that are directly linked to performance plan indicators over the FY 2000 level.

Rationale: Given the demands in health care that the IHS continues to face, it has become increasingly important to the IHS's advocacy role to seek collaborative partnerships with other organizations which can assist in efforts to achieve the IHS Mission and Goal. While the number of agreements was initially identified as the most appropriate indicator, it has become clear that number is less significant than the area of focus and level of commitment spelled out in the agreement. Thus, this indicator was revised to address increasing the number of agreements specifically directed at performance indicators.

Approach: For many years the IHS has worked collaboratively with other organizations, particularly other HHS agencies (e.g., NIH, CDC, AHCPH), in efforts to improve the quantity and quality of services we provide. The IHS is currently in the process of proactively seeking additional and broader partnerships with organizations directed at setting in place long-term strategic approaches to addressing the interactive effects of health and social services, community empowerment, and economic development directed towards improved quality of life for AI/AN people.

Clearly opportunities exist for expanding agreements with existing organizations as well as developing new ones with other Federal, State and local agencies, as well as private sector organizations. In this light, our Director is currently spearheading a Domestic Policy Council multi-departmental initiative for AI/AN children and youth around two themes:

1. Ensuring a safe and healthy home and community
2. Ensuring personal development within the context of developing communities

Response thus far has been encouraging with active participation from HUD, DOI, DOA, DOT, and several HHS OPDIVs. The ultimate goal for the initiative is to improve the status of AI/AN children and youth relative to indicators reflecting the two themes. The approach is to collaborate with agencies that serve AI/AN people to improve coordination of services and increase access to services for AI/AN communities (including urban areas). In addition, the initial workgroup of this initiative embraced the importance of agencies documenting their commitment to the initiative through identifying appropriate specific GPRA performance indicators.

Many additional opportunities exist to address major health problems through collaboration. These will be pursued with intent to include joint performance indicators as part of the collaborative process (e.g., see Indicator 11 on page 44).

Data Source: Audit of existing agreements.

Baseline: The FY 1999 total number of agreements was 86. The baseline for those FY 1999 agreements linked to performance measures will be determined by February 2000.

Type of Indicator: Process

Linkages: This indicator broadly supports the DHHS Strategic Plan, Strategic Objective 3.6 *Improve the Health Status of American Indians and Alaska Natives*.

Program Performance FY 1999: The FY 1999 indicator committed to increasing the total number of agreements with other agencies and organizations by 10% over the FY 1997 level that was originally reported at 71. Review of the documentation of FY 1997 revealed that only 66 were actually in effect. This indicator has been accomplished with 86 agreements for FY 1999 for a total of \$12.9 million compared to the 66 agreements in FY 1997 for a total of \$11.6 million. This represents a 30% increase in the number of agreements.

Indicator 36: During FY 2001, the IHS will expand Managerial Cost Accounting (MCA) capacity through the investment in necessary information technology in accord with DHHS and OMB guidance.

Rationale: The Federal Financial Management Improvement Act of 1996 (The Brown Bill) requires IHS to achieve the linkage of resources to results through MCA. This legislation requires each agency to maintain financial management systems that comply with Federal financial management systems requirements, applicable Federal accounting standards, and the U. S. Standard General Ledger at the transaction level. As mentioned in the *Program Aggregation* section on page 24, caution must be exercised in applying manufacturing

accounting approaches to a comprehensive public health program. Attempting to cost account for outcomes for complex chronic disease processes (i.e., diabetes) addressed by many health disciplines in diverse settings, with long time lags in effect, is plagued with threats to validity, and would probably represent an exercise in futility.

Approach: The IHS has contracted with the Mitretek Systems to analyze technical alternatives for IHS cost reporting/cost accounting. This will be a detailed analysis of technical alternatives and include a cost benefit and trade off analysis of alternatives. The results will be provided to a steering committee to support strategic decision making regarding the implementation of cost reporting and cost accounting at IHS. This system is necessary to assist IHS leadership to maximize the effective use of available resources and ensure that patient care can be provided to its customers. Perhaps the most significant benefit or goal for establishing MCA is to increase collections from private insurance, Medicare, and Medicaid.

Type of Indicator: Process

Linkages: This indicator supports the management and accountability requirements of GPRA, GMRA, Clinger-Cohen and a DHHS OPDIV.

Program Performance FY 1999: The FY 1999 indicator committed to begin implementation of cost accounting during FY 1999. This measure was accomplished with the implementation of "cost center" accounting practices which began operating at IHS health facilities, Area Offices, and Headquarters and have contributed to improved management particularly at hospitals and clinics.

Indicator 37: To improve job satisfaction and the quality of work life for IHS employees, the IHS will improve its overall Human Resource Management (HRM) Index score to at least 95 as measured by the DHHS annual HRM survey.

Rationale: The DHHS Quality of Work Life Initiative is based on social-psychological principles which are associated with both organizational effectiveness and improved quality of life for members. As part of this initiative, the Department has developed and refined a HRM Index employee survey as a valid measure of management practices that are important to organizational performance. These practices include Morale, Climate for Innovation, Planning and Organization, Communication, and Operational Efficiency. Since the DHHS started conducting the HRM Index surveys in 1991, the IHS sample scores have consistently averaged below the overall average DHHS score. Given that the elements assessed in this survey are fundamental to achieving the IHS Mission and Goal, the Agency is committed to improving this trend.

Approach: The IHS is now in the process of actively tailoring the implementation of the Department's Quality of Work Life Initiative to its unique and diverse setting. Furthermore, some of the additional resources in the requested FY 2001 IHS Budget will be used to improve supporting functions such as training, equipment and supplies, and improved communications networks. The Agency believes these enhancements, coupled with the Quality of Work Life Initiative, will improve morale, communications, job satisfaction, and other factors sufficiently to be reflected in an improved HRM Index score for the IHS in FY 2001.

Data Source: FY 2000 DHHS HRM Survey

Baseline: FY 1998 and FY 1999 DHHS HRM Survey Scores were 93 for the IHS

Type of Indicator: Process/Impact

Linkages: This is a new indicator for FY 2000 which directly supports the Secretary's Quality of Work Life Initiative and generally supports the DHHS Strategic Plan, Strategic Objective 3.6 *Improve the Health Status of American Indians and Alaska Natives.*

Program Performance FY 1999: No FY 1999 indicator

APPENDIX TO THE IHS 2001 PERFORMANCE PLAN

A.1 Approach to Performance Measurement

Data Verification and Validation

The IHS utilizes outside (non-IHS) and IHS data sources to manage its diverse programs and assess Indian health status. The two principal outside data sources are the Bureau of the Census and the Centers for Disease Control and Prevention, in particular, the National Center for Health Statistics (NCHS). The Census Bureau is the source of Indian population counts and social and economic data. However, reliable Indian census data at the county level are only available from the Decennial Census, once every 10 years. The IHS prepares AI/AN population estimates for years between the Census.

The NCHS provides IHS with natality and mortality files that contain all births and deaths for USA residents, including those identified as American Indian or Alaska Native. The NCHS obtains birth and death records from the State departments of health, based on information reported on official State birth and death certificates. The IHS receives these records with essentially the same basic demographic information as the records maintained by NCHS, but with names, addresses, and record identification numbers deleted as required by the Privacy Act. It should also be noted that tribal identity is not recorded in these records by the States. The State of New Mexico does identify tribal affiliation for 23 indigenous tribes of that state. However, the IHS does not obtain this tribal identification from the automated records provided by NCHS. The data are subject to the degree of accuracy of reporting by the States to NCHS. The NCHS does perform numerous edit checks and imputes values for non-responses. The IHS assigns IHS organizational (Area and service unit) identifiers to the birth and death records in setting up its Indian database. The IHS computer routines for accomplishing this have been thoroughly verified, and the results are continuously monitored.

Several studies have shown considerable miscoding of Indian race on State death certificates, understating Indian mortality especially in areas not associated with Indian reservations. The IHS now utilizes factors based on a National Death Index study to adjust Indian mortality rates for race miscoding. Another major problem with mortality data is the time lag in receiving data. These data are not typically available from NCHS until two years after the events occur, and mortality data are often slow in showing the impact of health interventions. Due to these constraints, IHS has chosen not to use mortality data for annual performance plan indicators except in special circumstances. The IHS will continue to use mortality data for tracking long-term trends in Indian health status and to make comparisons with other population groups. However, having to wait two years to link activities in an annual performance plan with mortality findings is of limited value in the ongoing implementation and evaluation process. The IHS would like to see greater emphasis on long-term strategic planning in the future, which could more effectively link the GPRA and HP 2010 process and depend, to considerable extent, on mortality data.

IHS Automated Data Systems

The IHS has its own program information systems to collect data on the services provided by IHS and tribal direct and contract programs. The software used by IHS facilities and most tribal facilities is the Resource and Patient Management System (RPMS). Data are collected for each inpatient discharge, ambulatory medical visit, and dental visit (all patient specific) and for community health service programs including health education, community health representatives, environmental health, nutrition, public health nursing, mental health and social services, and substance abuse (all activities reporting systems). The patient-specific data are collected through the Patient Care Component (PCC) of the RPMS. These data are subject to recording, inputting, and transmission errors. However, IHS software systems have extensive edits built in at the facility and central database levels to detect and correct a large part of the errors. Others that cannot be detected by computer are often discovered through the monitoring for reasonableness that is performed in the field and IHS Headquarters.

Each facility that utilizes PCC has a facility-level database that contains the detailed PCC data collected at that site. A subset of the detailed PCC data (to meet the routine information needs of IHS Headquarters) is transmitted to the IHS central database. The PCC data are the source of most of IHS' GPRA measures since they reflect prevention activities and morbidity and do not have the time lags described previously for mortality data. However, many of IHS' proposed measures rely on detailed PCC data not currently transmitted to the IHS central database.

The IHS is developing software to transmit some of these needed data items to the central database. In the meantime, IHS will need to use sampling routines to collect the required data from the individual facility-level databases. A stratified sampling approach will be used to include different types and sizes of facilities and Indian populations with different health characteristics. In some cases, the required data for a measure may not be part of PCC or, if it is, may not be coded at some facilities. Local surveys may need to be utilized in these areas to capture the required data. Standard survey questionnaires and procedures will be used whenever possible. The degree to which these activities will be achieved depends on the available infrastructure to address these demands in the face of the many competing priorities.

IHS Diabetes Audit

A final important data set that underpins the diabetes treatment indicators 2-5 is the IHS Diabetes Audit. Since 1986 a yearly medical record review to assess diabetes care has been conducted in more than 75% of the IHS and tribal facilities, representing care to nearly 70,000 AI/AN people with diabetes. Staff at participating facilities are encouraged to maintain active diabetes registries using uniform definitions. Each registry is maintained in the IHS computerized medical record system and includes information about individuals with diagnosed diabetes who have been seen at least once in the past three years. Each year a systematic random sample is drawn from each facility's registry, using a sample size sufficient to provide estimates of $\pm 10\%$ of the true rates of adherence for that facility with a confidence of $>90\%$.

The medical record review measures selected clinical interventions, performance measures, and intermediate outcomes using the uniform set of definitions. Chart reviews are conducted by the Area diabetes consultants and other professional staff trained by them in accordance with written instructions and definitions provided by the IHS Diabetes Program. The abstracted data are entered into a microcomputer-based epidemiologic software program. Summary reports are printed for immediate use by facility staff in their quality improvement and program planning

activities. Regional and national rates are constructed for each item of the medical record review after data are aggregated from all participating sites.

During the period 1995-1997, 150 sites submitted data to be compiled for the IHS total. Indian health facilities and tribally contracted facilities that do not provide direct patient services did not participate in the audit. Participation from each of the 12 IHS administrative regions varied by year and by federal or tribal management. All regions were represented in each year and approximately 2/3 of all the facilities contributed data in a given year. Tests of trend over the 3-year period were performed by the Mantel-Hanzel test except as noted in the text.

A.2 Changes and Improvements

The IHS FY 2000 Performance Plan and its 34 performance indicators have been revised based on updates in baselines and other data related issues that have been identified as part of implementing the FY 1999 plan. In addition, targets have been adjusted for certain treatment and infrastructure related indicators based on the actual FY 2000 IHS appropriation which was lower than the President's proposed IHS budget for FY 2000 in several categories.

The IHS FY 2001 Performance Plan include a management-related indicator for increasing the number of cost-saving contracts with vendors who provide services through the Contract Health Services mechanism and indicators to track suicide attempts and assure appropriate referrals for people at risk. In addition, the IHS is negotiating with CDC regarding collaboration on a pilot exercise/fitness initiative and performance indicator to support health promotion/disease prevention for obesity, diabetes, and heart diseases.

FY 1999 Performance Reporting

IHS has report on 20 of its 27 (74%) FY 1999 performance measures in the FY 1999 performance report included in this document. Data will be available on the remaining indicators by August of 2000, with the exception of Indicator 22 that will not be until December of 2002.

Revision to FY 2000 Performance Plan

The iterative process of developing the FY 1999-FY 2001 performance plans has required the IHS to audit many different data sets to assess current access to health services (coverage) and baseline rates of various conditions. During this process it has become increasingly clear that the continued diversion of available resources toward maintaining patient care in response to continued funding shortfalls has resulted in continued loss of the public health infrastructure that support data collection and analyses. Data sets that were previously well enumerated and maintained are now incomplete or under analyzed.

In light of these findings, the IHS has revised several indicators for FY 2000 to assure more reliable, timely and valid performance data. Furthermore, analyses of recent workload data have revealed continued declines in access to some services. Based on these trends and Congressional committee marks for the IHS FY 2000 budget below the President's request, we have reduced the target levels of a few indicators to reflect more realistic probabilities of accomplishment for FY 2000. The table that follows summarizes the significant changes in content or magnitude to FY 2000 indicators submitted with the FY 2000 budget.

Summary of Changes to the FY 2000 IHS Performance Indicators

Original FY 2000 Indicator	Revised FY 2000 Indicator	Rationale for Change
Indicator 2: By the end of FY 2000, increase by 3% the proportion of I/T/U clients with diagnosed diabetes who have improved their glycemic control over the FY 1999 level.	Indicator 2: Reduce diabetic complications by demonstrating a continued trend in improved glycemic control in the proportion of I/T/U clients with diagnosed diabetes in FY 2000.	It has been determined that three year running trend data (i.e., add the most recent year of data and drop the oldest year of data) is a more reliable for an ongoing measure.
Indicator 3: By the end of FY 2000, increase by 3% the proportion of I/T/U clients with diagnosed diabetes and hypertension who have achieved blood pressure control standards over the FY 1999 level.	Indicator 3: Reduce diabetic complications by demonstrating a continued trend in improved blood pressure control in the proportion of I/T/U clients with diagnosed diabetes and hypertension who have achieved blood pressure control standards in FY 2001.	It has been determined that three year running trend data (i.e., add the most recent year of data and drop the oldest year of data) is a more reliable for an ongoing measure.
Indicator 4: By the end of FY 2000, increase by 3% the proportion of I/T/U clients with diagnosed diabetes who have been assessed for dyslipidemia over the FY 1999 level.	Indicator 4: Reduce diabetic complications by demonstrating a continued trend of improvement in assessing the proportion of I/T/U clients with diagnosed diabetes for dyslipidemia (i. e., cholesterol and triglyceride) in FY 2000.	It has been determined that three year running trend data (i.e., add the most recent year of data and drop the oldest year of data) is a more reliable for an ongoing measure.
Indicator 5: By the end of FY 2000, increase by 3% the proportion of I/T/U clients with diagnosed diabetes who have been assessed for nephropathy over the FY 1999 level.	Indicator 5: Reduce diabetic complications by demonstrating a continued trend of improvement in the proportion of I/T/U clients with diagnosed diabetes who have been assessed for nephropathy in FY 2000.	It has been determined that three year running trend data (i.e., add the most recent year of data and drop the oldest year of data) is a more reliable for an ongoing measure.
Indicator 6: By the end of FY 2000, increase the proportion of women who have annual Pap screening to 55%.	Indicator 6: By the end of FY 2000, increase the proportion of women who have annual Pap screening by 3% over the FY 1999 baseline.	Performance level adjusted based in FY 2000 appropriation and need to establish new baseline independent of the diabetes audit formerly used.
Indicator 7: By the end of FY2000, assure that at least 30% of the AI/AN female population 50-69 years of age have had screening mammography during the previous year.	Indicator 7: By the end of FY2000, assure that at least 30% of the AI/AN female population 40 years of age and older have had screening mammography during the previous year.	The CDC has changed its recommended age range for regular mammography from women 50 and older to women 40 and older.
Indicator 13: By the end of FY 2000, assure that the percentage of AI/AN children 6-8 and 14-15 years who have received protective dental sealants on permanent molar teeth is increased by 5% over the FY 1998 GPRA Dental Pilot Dental Project. level.	Indicator 13: By the end of FY 2000, assure that the percentage of AI/AN children 6-8 and 14-15 years who have received protective dental sealants on permanent molar teeth is increased by 3% over the FY 1999 IHS Oral Health Survey rate.	Performance level adjusted based in FY 2000 appropriation. The baseline has been changed to allow comparison with the more accurate 1999 Oral Health Survey findings.

Original FY 2000 Indicator	Revised FY 2000 Indicator	Rationale for Change
Indicator 16: By the end of FY 2000, at least 25% of the Urban Indian health care programs will have implemented mutually compatible automated information systems which captures health status and patient care data.	Indicator 16: By the end of FY 2000, the Urban Indian health care programs will have field tested in at least one site, a mutually compatible automated information systems which captures health status and patient care data.	Performance level adjusted based in FY 2000 appropriation.
Indicator 18: By the end of FY 2000, implement the OMB approved IHS-wide consumer satisfaction survey protocol and determine baseline level of satisfaction with the acceptability and accessibility of health care.	Indicator 18: By the end of FY 2000, obtain OMB clearance for IHS-wide consumer satisfaction survey and protocol and determine baseline level of satisfaction with the acceptability and accessibility of health care.	Submission for OMB clearance was delayed in FY 1999, but it is anticipated that it will occur in time to achieve baseline levels for FY 2000.
Indicator 19: Assure that by the end of FY 2000, the total number of public health nursing services (primary and secondary treatment and preventive services) provided to individuals in all settings and the total number of home visits are increased by 15% over the FY 1997 workload baselines.	Indicator 19: Assure that by the end of FY 2000, the total number of public health nursing services (primary and secondary treatment and preventive services) provided to individuals in all settings and the total number of home visits are increased by 7% over the FY 1997 workload baselines.	Performance level adjusted based in FY 2000 appropriation.
Indicator 20: During FY 2000, increase by 3% the proportion of AI/AN children who have completed all recommended immunizations by the age two over the FY 1999 rate.	Indicator 20: During FY 2000, increase by 2% the proportion of AI/AN children who have completed all recommended immunizations by the age two over the FY 1999 rate.	Performance level adjusted based in FY 2000 appropriation.
Indicator 21: By the end of FY 2000, increase by 3% overall pneumococcal and influenza vaccination levels among adults aged 65 years and older to 60%.	Indicator 21: By the end of FY 2000, increase by 2% the overall pneumococcal and influenza vaccination levels among adults aged 65 years and older over the FY 1998 rate.	Performance level adjusted based in FY 2000 appropriation.
Indicator 22: By the end of FY 2000, reduce deaths by unintentional injuries for AI/AN people to no more than 90 per 100,000 people.	Indicator 22: By the end of FY 2000, reduce injury-related hospital discharges for AI/AN people to no more than 71.5 per 10,000 people.	Injury mortality data have been difficult to secure in reasonable timeframes. The rate of hospitalization for injuries is probably a better proxy for actual injury rate and is available directly through IHS data sets.

Original FY 2000 Indicator	Revised FY 2000 Indicator	Rationale for Change
Indicator 28: By the end of FY 2000, develop and implement an environmental health surveillance system to provide the information needed to identify environmental health issues, establish local and regional priorities, and develop and evaluate environmental interventions and programs.	Indicator 28: By the end of FY 2000, develop the protocol and implementation plan for an environmental health surveillance system to provide the information needed to identify environmental health issues, establish local and regional priorities, and develop and evaluate environmental interventions and programs.	Performance level adjusted based in FY 2000 appropriation.
Indicator 29: By the end of FY 2000, IHS will reduce 1998 Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) by 6%.	Indicator 29: By the end of FY 2000, IHS will have completed an evaluation of the current \$445,759,000 listing of the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) and addressed \$12 million of the FY 1999 BEMAR listing.	Performance level adjusted based in FY 2000 appropriation.
Indicator 30: By the end of FY 2000, provide sanitation facilities projects to serve 5,900 new or like-new homes and 9,930 existing Indian homes.	Indicator 30: By the end of FY 2000, provide sanitation facilities projects to serve 3,740 new or like-new homes and 11,035 existing Indian homes.	Performance level adjusted based in FY 2000 appropriation.
Indicator 31: Improve critically needed access to health care services by continuing construction of the Ft. Defiance, Arizona Hospital and the Parker, Arizona Health Center; completing the designs of facilities at Red Mesa, Arizona and Pawnee, Oklahoma; and providing new or replacement dental units by the end of FY 2000.	Indicator 31: Improve access to health care by continuing construction of the replacement hospital in Fort Defiance, Arizona; starting construction of the replacement hospital in Winnebago, Nebraska; continuing construction of the replacement health center in Parker, Arizona; designing the new health center in Red Mesa, Arizona; designing and starting construction of the staff quarters to support the hospital in Zuni, New Mexico; and continuing the design and construction of dental units.	Performance level adjusted based in FY 2000 appropriation.
Indicator 32: By the end of FY 2000, the IHS will have improved the level of consultation and opportunities for participation for its I/T/U partners as demonstrated by a 5% increase in score over the FY 1999 satisfaction survey.	Indicator 32: During FY 2000, the IHS will work with I/T/U stakeholders to revise the consultation process and develop an appropriate survey instrument and protocol to assess I/T/U satisfaction with the IHS consultation process.	Stakeholder interest in revising the IHS consultation policy and including guidance for the implementation process resulted in a delay of using the instrument developed in FY 1999 to collect baseline rates. Thus for FY 2000 the instrument will be revised in concert with the revisions to the consultation process. In addition, the survey will be submitted to OMB for clearance to allow the IHS to support the process.

Original FY 2000 Indicator	Revised FY 2000 Indicator	Rationale for Change
Indicator 34: During FY 2000, the IHS Headquarters and Areas will maintain full compliance with major Federal requirements (i.e., GPRA, GMRA, ITMRA, etc.), without expanding the administrative staff above the FY 1998 FTE level.	Indicator 34: During FY 2000, the IHS Headquarters and Areas will maintain full compliance with major Federal requirements (i.e., GPRA, GMRA, ITMRA, etc.), without expanding the administrative staff above the FY 1999 FTE target level of 10% below the FY 1997 level.	The reduction in FTEs that occurred in FY 1998 and FY 1999 were more than anticipated (22% below FY 1997) leaving "functional holes" in the IHS infrastructure. Some of these functions must be restored to meet accountability requirements so the target FTE level will be at the FY 1999 target level (i.e., 10% below the FY 1997 level).
Indicator 35: By the end of FY 2000, the IHS will have increased the number of interagency agreements and cooperative agreements with agencies and organizations that are directed at improving the health status and/or the quality of life of AI/AN people by 5 % over the FY 1999 level.	Indicator 35: By the end of FY 2000, the IHS will have increased the number of interagency agreements and cooperative agreements with agencies and organizations that are directly linked to performance plan indicators over the FY 1999 level.	The number of agreements is not a reliable and valid measure of the level of collaboration relative to the performance effort. For example, several agreements have been folded into a single larger agreement. This reflects a decrease in the number of agreements, but a higher level of collaboration.
Indicator 36: By the end of FY 2000, the IHS will have fully implemented Managerial Cost Accounting (MCA) in accord with DHHS and OMB guidance.	Indicator 36: By the end of FY 2000, the IHS will continue the implementation of Managerial Cost Accounting (MCA) through the development of transitional pilot sites in accord with DHHS and OMB guidance.	Performance level adjusted based in FY 2000 appropriation and an anticipated delay the implementation of needed data systems across local health care facilities.
Indicator 37: For FY 2000, the IHS will improve its overall Human Resource Management (HRM) Index score to at least 95 as measured by the DHHS annual HRM survey.	Indicator 37: For FY 2000, the IHS will improve its overall Human Resource Management (HRM) Index score to at least 94 as measured by the DHHS annual HRM survey.	Performance level adjusted based in FY 2000 appropriation.

A.3 Linkage to HHS and OPDIV Strategic Plans

The IHS FY 2001 Plan was developed in the context of the IHS component of the HHS Strategic Plan and the four broad strategic objective described in Section 1.1. From the perspective of the HHS Strategic Plan, every indicator selected directly or indirectly supports Objective 3.6 *Improve the Health Status of American Indians and Alaska Natives*. Furthermore, most indicators also address multiple other Department objectives and are listed in the "Linkages" section of each individual indicator.

A.4 Performance Measurement Linkages with Budget, Cost Accounting, Human Resources, Information Technology Planning, Capital Planning and Program Evaluation

Performance Measurement Linkages with Budget

One of the greatest challenges of implementing the GPRA in a public health program is responding to the requirements of demonstrating an outcome focus on one hand and better linkages to funding (and hence, costs) on the other. These are difficult and in some cases impossible goals to mutually accomplish. The IHS has integrated the use of process, impact and a few outcome indicators but because many health outcomes cannot be realized in a one-year plan, we have predominantly focused on activities that have an evidenced-based association with positive health outcomes over time (impact).

To attempt to enhance short-term detailed cost accounting as well as discipline specific outcome assessment capability would require the reprogramming of a significant proportion of resources away from patient care into administrative infrastructure. Such an effort would run against current trends and directives from the Department, Congress, OMB and our stakeholders. We contend given these realities, our plan meets the requirements and intent of the GPRA and more than adequately strengthens the connection between showing how health care funding is annually prioritized to the problems of greatest concern of our consumers. Health outcomes (i.e., mortality and morbidity) are well articulated annually in our publication *Trends in Indian Health*, but which present data that are two to three years old because of delays in the Nations data system infrastructure.

The IHS has elected to keep general reference to funding levels in the plan and built estimated accomplishment around the request funding level. We can identify which requested funding enhancements are generally linked to supporting specific indicators in some cases. While the linkage would be relatively clear and direct in the case of public health nursing or dental care related indicators, it would get more complex with the diabetes-related indicators and extremely vague in the case of consumer and employee satisfaction related indicators. Applying a linear single path manufacturing accounting model to many health problems and management issues in a comprehensive public health program such as the IHS is not feasible.

We have selected an aggregation approach largely based on the way our programs are managed and have selected four functional areas for the aggregation of the 24 budget categories identified in the IHS "Detail of Change Table": 1.) Treatment, 2.) Prevention, 3.) Capital

Programming/Infrastructure, and 4.) Consultation, Partnerships, Core Functions, and Advocacy. While this approach may appear to be an overly simplistic "lumping" of categories, it is important to realize that there is no aggregation or disaggregation that allows mutually exclusive activities linked to mutually exclusive health problems. For a more detailed discussion of these issues, see the *Program Aggregation* section on page 24 of this document.

Cost Accounting

Beginning in FY 1997, the IHS contracted with the Mitretek Systems to analyze technical alternatives for IHS cost reporting/cost accounting. This provided a detailed analysis of technical alternatives and a cost benefit and trade off analysis of alternatives. The results have been provided to a steering committee to support strategic decision making regarding the implementation of cost reporting and cost accounting at IHS. This system is necessary to assist IHS leadership to maximize utility of diminishing resources, be cost effective, and ensure that patient care can be provided to its customers.

Most recently, the steering committee met during the week of August 2, 1999, in Portland, Oregon. The immediate objective of this workgroup was to review, revise and expand the cost center structure of the agency. All the current 95 cost center specifications were reviewed for content and current applications. The workgroup has recommended that some of the current cost centers be deleted in future years.

Likewise, several new cost centers will be recommended for development. These reflect current technology, terminology and healthcare practices that will further help to delineate the agency's costs. It is anticipated that a larger workgroup will further revise the cost center in FY 2000 as well as look at other cost accounting issues and direction.

Human Resources

The IHS is committed to human resource development as an essential component of performance planning and performance management. Historically, we have consistently invested in long and short-term training in the clinical, public health, and management/leadership areas to assure capable providers and public health leaders. In recent years we have reduce these investments to in order to support other priorities. The effects of these reductions in training are undoubtedly multiple but perhaps most evident in growing staff retention difficulties. That these two problems are related was confirmed in surveys of employees leaving the IHS, who indicated that a lack of training opportunities was a significant determinant in their decision to leave.

Across budget categories in the requested FY 2001 IHS budget is a renewed commitment to find cost effective approaches to better meeting human resource development needs including clinical, public health, management, information technology, and teamwork. Through our Quality of Work Life initiative, the IHS has attempted to align its performance goals with its human resource management efforts in several ways. One, IHS has began a process by which future executives are identified and trained to take over top leadership positions one they become available. Primarily, the use of candidate development programs at all levels is the process that we will be using. Two, there is a large push to train our present and future leadership cadre at the lower levels by offering courses like Leadership in Context which focuses on leadership behaviors at all levels, and Leadership 2000 which focused on leadership behaviors at the individual contributor level. Three, we are planning to train a cadre of internal consultants/coaches to offer support and infrastructure to the change in culture that will be

needed for the future of Indian health. Four, there is a major push toward flexibility in working conditions for all employees, like flexiplace, flexitime, etc.

We use the Human Resource Management Index (HRMI) to determine if our Human resource program is meeting employee and management expectations. The HRMI measures 14 different work related issues ranging from management culture to employee morale. The IHS HRMI score has been identified as a performance measure in both the FY 2000 and FY 2001 IHS Performance Plans (see Indicator 37 on page 82) and we expect to raise the HRMI score by at least one point each year to document performance improvement.

Information Technology Planning

The Clinger-Cohen Act (CCA) of 1996 (formerly the Information Technology Management and Reform Act), established new requirements for the information technology (IT) planning process that emphasize the management of IT resources as a "capital investment" and link these IT planning activities to budget and performance measures. The Act reflects the growing importance that the management of IT resources plays in contributing to efficient government operations. The IHS is working to integrate CCA activities in support of GPRA efforts and visa versa.

The IHS budget formulation process is the mechanism through which the portfolio of IT investments is selected and funded. Increased attention needs to be given to the economic and business justification of major investments. During the budget execution phase, an intensified management control process will be established to ensure performance goals are achieved, and that IT projects are delivered on time, within budget, and perform as intended.

The establishment of an IT investment review process as required by CCA represents a major paradigm shift in IT planning, acquisition and management. Because of this, IHS efforts have focused on educating I/T/Us in the new IT management process and providing technical guidance in the development of IT management processes consistent with their operational and management environments.

During FY 2001, the IHS will establish an agency-wide IT Investment Review Board (ITIRB) and policies and procedures on IT capital planning and investment control processes in accordance with CCA requirements and Departmental guidelines. The IHS' approach to CCA implementation will follow the example of the Department in delegating responsibility and authority to the Area Directors for Area IT capital planning and investment control.

As part of the requirements of GPRA and the CCA, performance measurement is an essential part of effective management. CCA requires IHS to measure the contribution of IT investments to mission results. A key goal of the CCA is for agencies to have processes and information in place to ensure that IT projects are implemented at acceptable costs, within reasonable and expected time frames, and are contributing to tangible, observable improvements in mission performance. To effectively link strategic and IT capital planning along with the budget process, IT performance measurement efforts must monitor the performance of IT investments/projects to address whether they are effectively supporting the mission and programs of IHS.

Capital Planning

Capital asset planning for health care facilities construction is done in accordance with the IHS Health Care Facilities Priority System Methodology and submitted to OMB through Circular A-11, Preparation of Budget Estimates, Section III for reporting capital assets. These issues are represented in this performance plan by the three Capital Programming/Infrastructure Indicators 29-30 beginning on page 70.

Program Evaluation

In recognition of the growing importance of evaluation in supporting the IHS Mission, Goal and GPRA performance planning, the IHS has elected to add this section addressing program evaluation for FY 2000. The IHS evaluation process seeks to include American Indians and Alaska Natives as primary stakeholders in defining the purpose, design, and execution of evaluations. Stakeholders are the users of the end product of evaluations and typically are the population or groups most likely to be affected by the evaluation findings. The IHS has worked with its stakeholders in identifying and implementing principles of responsive evaluation practice and setting evaluation priorities.

The purposes of IHS evaluation efforts are:

- to advise the Director of the IHS on policy formulation; to conduct and manage program planning, operations research, program evaluation, health services researches, legislative affairs, and program statistics
- to develop the long-range program and financial plan for the IHS in collaboration with appropriate agency staff
- to coordinate with HHS, Indian Tribes, and organizations on matters that involve planning, evaluation, research and legislation
- to develop and implement long-range goals, objectives, and priorities for all activities related to resource requirements and allocation methodologies and models.

The Office of Public Health (OPH) serves as the principal advisory office to the IHS on issues of national health policy and coordinates these four evaluation functions:

- *Health Program Evaluations*--Collect and analyze information useful for assisting IHS officials in determining the need for improving existing programs or creating new programs to address health needs.
- *Policy Analysis*--Conduct analyses when a change in the IHS health service delivery system must be considered, when issues emerge in an area where no policy currently exists, or when current policies are perceived as inappropriate or ineffective.
- *Health Services Research*--Undertake analyses of the organization, financing, administration, effects, and other aspects of the IHS.
- *Special Studies and Initiatives*--Conduct studies and prepare special reports required by Congress in response to pending legislation or policies, often using a roundtable whenever an issue or a health problem requires immediate action and it is unclear what type of action should be taken.

The OPH meets part of the IHS evaluation needs with two major types of short-term studies: policy or program assessments and evaluation study. The policy study contributes to IHS decision making about budget, legislation, and program modifications and includes background

information to support IHS initiatives. Evaluation studies are carried out at the program level, or area offices, and focus on specific program needs.

Annually, OPH identifies the high-priority health care and health management issues and concerns through the submission of headquarters and area office proposals for assessment or evaluation. IHS area and associate directors submit proposals for possible areas of evaluation study. These proposals are reviewed and rated by a panel of subject-matter experts and evaluation experts and also reviewed by IHS staff for more specific concurrence with IHS strategic goals, objectives, and priority areas. The proposals are then ranked by priority and forwarded to the OPH for review and approval. The Director of the IHS reviews the final proposals and decides the respective funding levels.

Summary of Relevant Evaluations Activities

Several recent evaluation projects have significant direct and/or indirect implications for IHS performance planning and are thus summarized below:

Level of Need Funded Study Part 1: Benefit Package Costs for All Indians: This study, which is currently in draft report status, was designed to answer the question: *What would it cost to provide an equitable level of health care services to all eligible Indian people?* The research team used an actuarial analysis approach to address factors that affect the cost of providing health care benefits. The Federal Employee Health Benefits Plan was used as the benchmark for coverage and cost (i.e., premiums, co-payments, and deductibles) and adjustments were made for the population's age, health status, location, and estimated payments by other insurers (i.e., Medicare, Medicaid, and private).

The finding revealed that a health care package comparable to the Federal employee's provided to all 2.4 million AI/AN would cost \$2,980 per person for a total cost of \$7.4 billion annually. This same coverage applied to the current 1.34 million using the IHS system would cost approximately \$4 billion with about 25% of the cost expected to come from other sources (i.e., Medicare, Medicaid, and private). IHS appropriations provide only 59% of net funding needed for the 1.34 million Indian users and an additional \$1.2 billion would be needed to raise the level of need funded to 100%. The cost to expand coverage to the 1 million eligible Indians not now served by the Indian health care system would be an additional \$3 billion.

Diabetes in the Native American Population: The purpose of this project is to evaluate the effects of intensive counseling and drug management on the lowering of HgA1c's hypertension control and compliance with annual exams through a pharmacy practitioner diabetes program. The current Santa Fe Service unit (SFSU) HgA1c average is 8.3%. This is a reduction from 9.4% in 1995. It has been suggested that this reduction is due to the increased use of metformin at the SFSU. The cost of this agent for the past 2 years at SFSU alone totaled \$45,303. The estimated cost of all diabetic medication in FY 97 was \$31,750. The proposed use of another new agent troglitazone has the potential of triple this dollar amount. The project will attempt to limit these expenses by providing intensive counseling on the use of medications, reinforcing dietary and lifestyle changes and recommended by the dietician, reinforcing the use of self-blood glucose monitoring, and adjusting medication per protocol or doctors orders. The findings from this study underpin many of the strategies used in to achieve Indicators 2-5.

Evaluation of the Behavioral Risk Factor Surveillance System's Results and their Applicability to the Native Population of Anchorage: The purpose of this evaluation study is to determine the relative accuracy, validity and reliability of the Behavioral Risk Factor Surveillance System (BRPSS) risk estimates of the Anchorage Native population compared with data collected using other techniques that include (a) door-to-door household surveys, (b) key informant surveys, and (c) intercept data collection from Natives seeking primary care services in Anchorage from the Alaska Native Medical Center and the Primary Care Center.

The findings have significant implications for the most efficient and effective approaches to delivering health services and thus achieving many of the performance measures in this plan.

Evaluating the impact of primary intervention techniques on the dental caries rate in children living in southwest Alaska Native villages: The project will identify the reason why some communities in Bristol Bay have significant higher/lower caries rates in children than do other children in other Bristol Bay communities. Children aged 6-8 have been selected for the project. Since there are multiple contributing factors from caries, multiple risk factors must be reviewed to properly assess the risk for disease. The results of the project will be used to identify the factors that create high risk communities. A community model will be developed for use in allocating specific techniques including use of fluoridated water, consistent topical fluoride application, village education and support will reduce decay by an average of 2-3 surfaces per child at the end of those years.

Alaska Native Teen Tobacco Cessation Project: The purpose of the Alaska Native Teen Tobacco Cessation Project is to (1) help the youth who participate in the project to quit tobacco, 2) motivate the youth to become tobacco prevention and cessation advocates in their communities, and 3) determine the effectiveness of the cessation camp model in helping youth to quit tobacco. The utility of the study is to provide health educators, parents, teachers, community health aids, and other community health workers with information about the effectiveness of this particular approach to teen tobacco cessation.

This project will provide important information and strategies relevant to the development of Tobacco Control Centers as outlined in Indicator 26.

Assessing Substance Abuse Treatment Outcomes for Native Americans Residing on the Reservation: This study will provide a description of the severity of the participants' problems across eight domains (medical, legal, employment, social, drug use, psychological and spiritual) prior to intervention, and for up to 24 months after intervention. This description will provide the basis upon which improvements of the treatment program can be made. Areas that should be targeted for specific populations will be identified. In addition, the study will produce a set of manuals documenting the interventions provided by Indian Rehabilitation, Inc., in a manner that will allow replication by other facilities.

Methodology for Adjusting IHS Mortality Data for Inconsistent Classification of Race-Ethnicity of American Indian and Alaska Natives Between State Death Certificates and IHS Patient Registration Records:

The findings in this study indicate that on 10.9 percent of IHS Indian records matched to national death records, the race reported for the decedent was other than American Indian or Alaska Native. The percentage of records with inconsistent classification of race varied considerably among the IHS Areas. Recommendations included replicating the study using data on deaths occurring since 1988, using the adjustment factors developed in the study, and working with States to decrease inconsistent race reporting. While the significance of the study is not profound in terms of the performance indicators in this plan (i.e., the indicators are not based on State death certificates), the long-term significance in monitoring mortality disparities for the AI/AN population is critically important. The adjustments factors developed from this investigation are now being utilized in calculating AI/AN mortality rates in all the IHS publications.

Evaluation of the Indian Health Service (IHS) Adolescent Regional Treatment Centers: The principal conclusion based on this study's findings is that regional treatment centers have developed effective adolescent alcohol and substance abuse programs. The continuity of care and aftercare, however, is the biggest problem. The regional treatment centers need additional mental health staff resources, client charting improvements, and innovative ways to increase family involvement. Recommendations include improving the continuum of care to adolescent substance abusers, self-evaluation, and regional treatment center effectiveness and efficiency. This evaluation effort served as a major determinant in selecting Indicator 9 for this plan that addresses follow-up care for youths returning from regional treatment centers.

Evaluating the Effectiveness of Alcohol and Substance Abuse Services for Native American and Alaska Native Women: Phase II Final Report:

This evaluation provides both qualitative and quantitative information about a group of women that has been traditionally underrepresented in research. The life conditions of women about whom information was gathered are extreme, and for many women, adverse or abusive childhood experiences and conditions have carried through to adulthood. The vast majority of women were exposed to various types of abuses--such as physical, sexual, and emotional abuse--from childhood to adulthood. Women entered treatment through a variety of ways. Those who were mandated tended to enter treatment as an alternative to incarceration. Women hear about the availability of services through the court system, word-of-mouth, or through a community or an American Indian and Alaska Native social service agency. Women in the focus groups tended to select their current alcohol and other drug treatment program over alternatives because of its focus on American Indian and Alaska Native tradition and culture. The women and staff also espoused the benefits of the family-like environment that the treatment centers promoted. The availability of women-centered, family-focused approaches to alcohol and other drug treatment is severely limited in the United States. Several barriers to services for potential participants exist. The leading obstacle for parenting women is the lack of child-care for their children while in treatment. It was strongly emphasized that a woman's recovery was dependent on three key factors: herself, her social networks, and her community.

Partially based on the findings of this evaluation, this plan includes indicators which address policies and procedures for dealing with substance abusing women (Indicator 10) and for identifying, treating and/or referring victims of family violence, abuse or neglect (Indicator 14).

Prior Trauma Care of Intoxicated Patients as a Predictor of Subsequently Fatal Injury: The IHS has funded a study that includes the preliminary data collection, crude data reporting, and initial death certificate-hospital record linkage for alcohol related fatalities. The purpose of this study is to identify intervention opportunities associated with nonfatal, alcohol-related injuries reported in IHS emergency departments and clinics that could, over time, decrease alcohol-related injury death in the Billings, Montana, Service Units. This study is providing baseline data for post-intervention comparisons by expanding the existing database about alcohol-related injuries and death. The findings are being used to identify different intervention and prevention strategies directed at decreasing alcohol-related injuries and deaths in the Billings, Montana, Service Units. Injury-control efforts include a new policy regarding referrals by emergency room treatment staff to alcohol treatment staff. Prevention of alcohol-related injuries and deaths will also include activities focused on informing youth about the relationship between alcohol consumption and high-risk behavior. The findings of this evaluation effort underpin the interventions that are being used in achieving Indicator 22 in this plan addressing the reduction of unintentional injury mortality rates.

Resource Requirements Methodology Update: In the early 1970's, the IHS formulated the Resource Requirements Methodology (RRM) as a management tool to provide a comprehensive, systematic, and uniform process for estimating the level of resource requirements necessary to provide adequate health care to IHS customers and to assist in the allocation of non-earmarked resources. To reaffirm the purpose of the RRM, a study was conducted in 1995 to determine the validity and accuracy of the present methodology for use in today's health care environment. Preliminary findings support the need to update the current methodology to meet the future program demands of the IHS. The will consist of the following phases: (1) Update Staffing Criteria and Modules, (2) Formulate Needs Assessment Cost Model, and (3) Needs Assessment Model Training. This methodology is critical to planning the achievement of most of the health service related indicators identified in this plan.

Development of a Health Services Research Agenda for American Indian and Alaska Native Populations: The IHS and the Agency for Health Care Policy and Research cosponsored a health services research conference as a first step in a long-term agenda-setting process to identify the most important health services research issues facing AI/AN communities and their health care systems over the next 5 to 10 years. The health services research agenda is intended to promote collaboration among American Indian or Alaska Native organizations, tribal and urban health systems, medical communities, foundations, and government agencies to increase communications and produce research information on health program services for the American Indian or Alaska Native patient. The health services research agenda is also intended to provide a forum for discussing health care reform changes that are creating new directions in the Indian health care system.

The agenda developed from this conference will serve as a priority guide in achieving Indicator 35 in this plan that seeks to increase collaborative partnerships with other organizations.

New Directions for Evaluation

The IHS is responding to dramatic changes taking place inside and outside the Government including greater involvement of tribal governments in the Indian health care system, technological innovations, the changing patterns of disease to more chronic conditions, and the transfer of many Federal programs and resources to individual States. These changes will affect the IHS evaluation strategy in the coming years. Nevertheless, the IHS remains committed to comprehensively community-based, preventive, and culturally sensitive projects that empower tribes and communities to overcome health issues. Specific research and evaluation proposals currently in process include the following topics: evaluation of the effects of medical nutrition therapy on patient outcomes among Native Americans with newly diagnosed type II diabetics, evaluation of the elders clinic at the Zuni (New Mexico) Ramah Service Unit, and the evaluation of the impact of the Northern Cheyenne End-Stage Renal Disease Prevention Project.

In addition, the Director of the IHS has increased emphasis on several areas consistent with the Secretary's initiatives and the DHHS Strategic Plan. These initiatives focus on women's health, youth, traditional medicine, elder care, and establishment of working relationships with Federal and State governmental agencies. These initiatives will undoubtedly affect new directions for evaluation.